

# RHODE ISLAND



## *Medical Journal*

Volume XLIV, No. 1

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# The RHODE ISLAND MEDICAL JOURNAL

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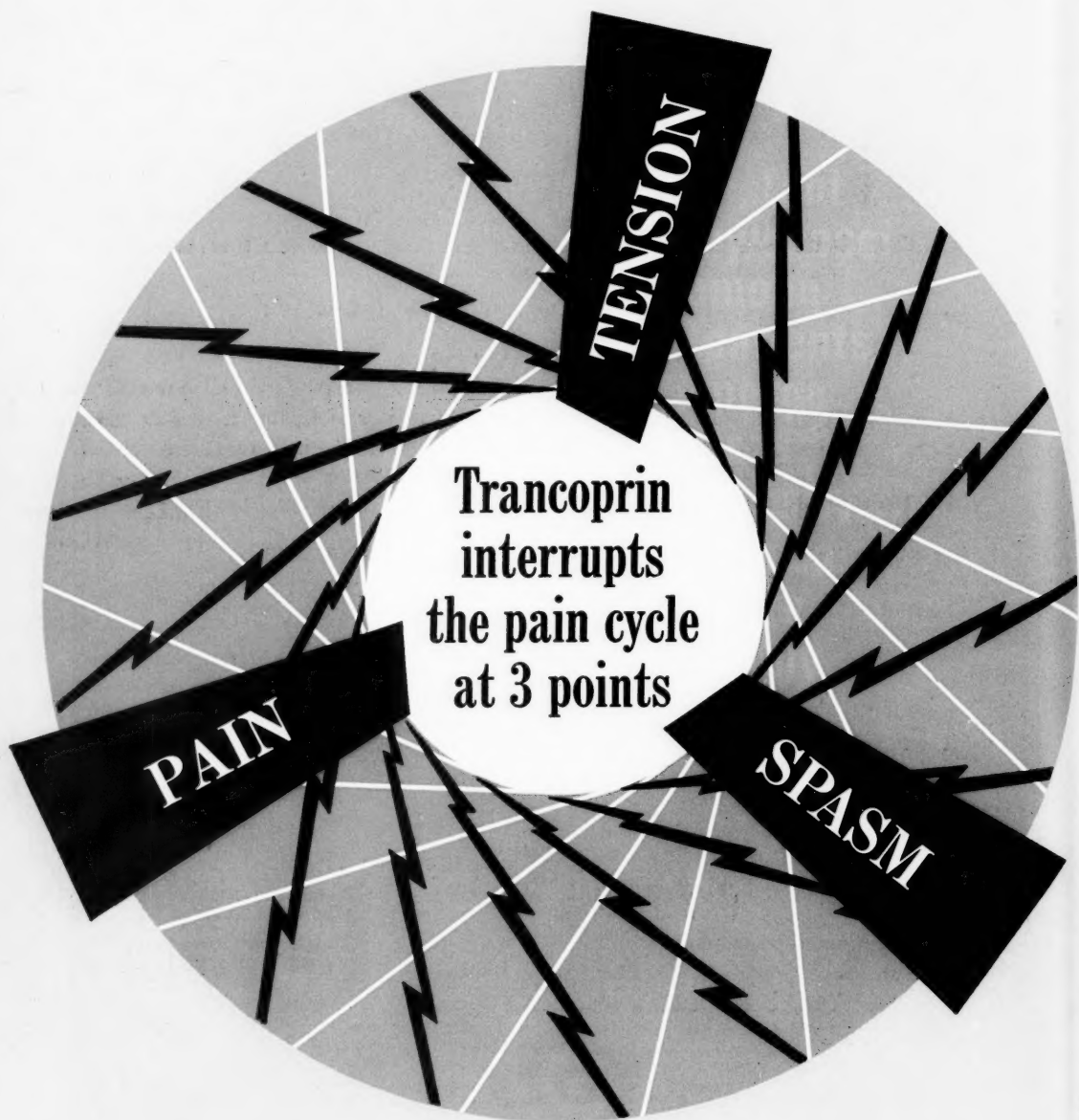
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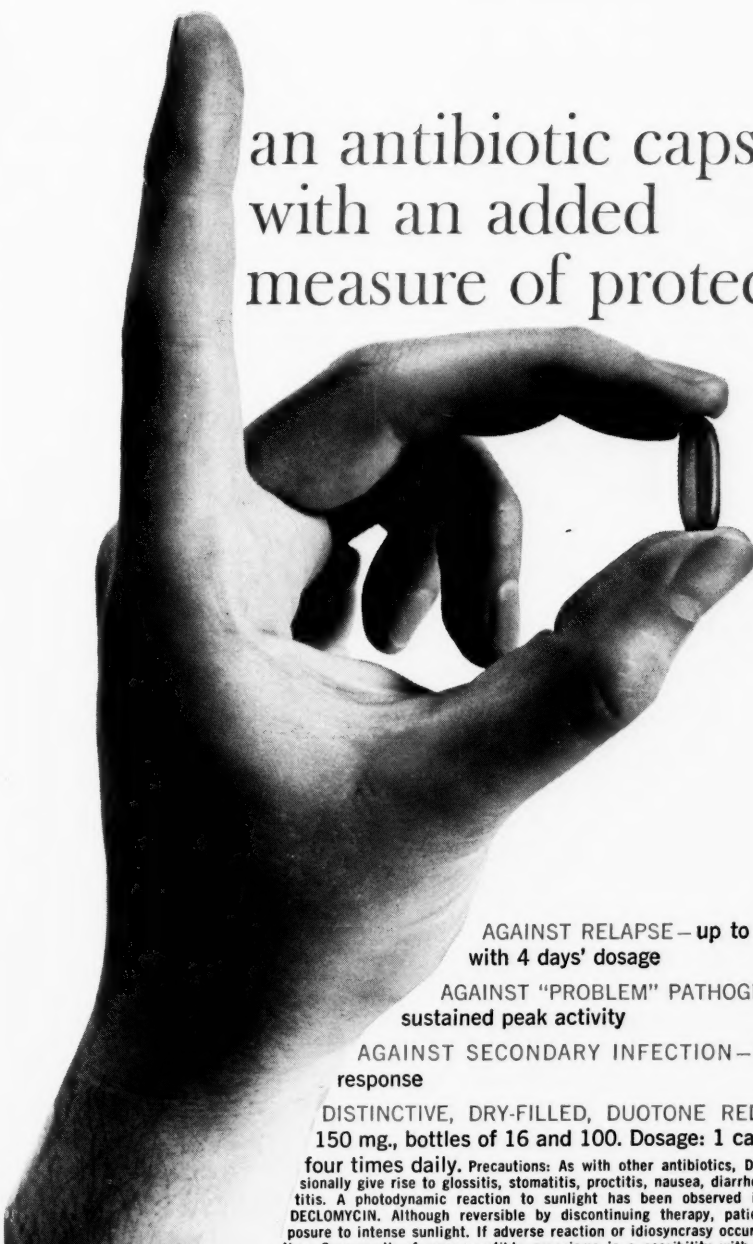
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## THE MAIL BOX

### TO THE EDITOR:

I think the proposal of having a *Letters to the Editor* department is an excellent one. I think it will stimulate interest in the JOURNAL in much the same way that this does in lay publications — sometimes I feel the *Letters to the Editor* in the local newspaper gets read as much as the comic strips. As regards the other two features proposed, they will, of course, depend upon the co-operation of the members, and I hope that it will be forthcoming.

I am sure that under your guidance the JOURNAL is due for a lively future.

Sincerely yours,

IRVING A. BECK, M.D.

### *Thanks to the Medical Bureau*

164 Sharon Street,  
Providence, R. I.  
November 4, 1960

Dr. John C. Ham  
Providence Medical Bureau  
Providence, Rhode Island

Dear Doctor Ham:

On Sunday evening, October fourteenth, my mother was stricken ill. Our family physician was out of the city, so the call was serviced by the Medical Bureau. The telephone operator on duty calmly and efficiently arranged to send a substitute doctor and the Rescue Squad from the Fire Department. Within ten minutes my mother was receiving emergency treatment. Later she was removed to the hospital.

### DID YOU KNOW?

- That the average American consults a doctor about his health five times a year.
- That in an average year, Americans have 115 million colds severe enough to restrict activity or require medical attention.
- That there are some 1,200 insuring organizations currently providing health insurance to the public.
- That the residents of every state in the nation except Alaska can choose from among more than 100 insuring organizations in selecting their health insurance, and that Alaskans have a choice of 74 insuring organizations.
- That some 2.4 million Americans have ulcers, and that nearly three times as many men as women are so affected.

My family and I are most grateful to the Medical Bureau for this remarkable service, and deeply indebted to the operator who was on duty.

Sincerely yours,

GRACE D. HEALEY

### *Journal Book Review Wins Praise*

Department of the Army  
The Historical Unit,  
U. S. Army Medical Service,  
Walter Reed Army Medical Center,  
Washington 12, D. C.

28 November 1960

Thomas C. McOsker, M.D.  
144 Waterman Street  
Providence 6, Rhode Island

Dear Doctor McOsker:

Your review in the October 1960 RHODE ISLAND MEDICAL JOURNAL of the second neurosurgical volume in the series dealing with the history of the U. S. Army Medical Department in World War II has given me a great deal of pleasure. I was particularly pleased over your comment on how stimulating differences of opinion among authors may be. I was also amused, for some of the production editors who first worked on this volume and who were innocent of all knowledge of medicine thought this was pretty awful and demanded that such differences be reconciled.

I shall call your review to the attention of Doctors Spurling and Woodhall, the editors of the neurosurgical series, and to the various authors. I know they will all be pleased with your remarks as I am.

The World War I Medical Department history, as you probably know, was not properly publicized, and many mistakes were made in World War II that would not have happened if the vast amount of information it contains had been widely known. That isn't going to happen with the World War II history, I am happy to say, thanks to such stimulating reviews as yours, and to the co-operation of the journal editors who distribute our books for review.

Sincerely yours,

JOHN BOYD COATES, JR.  
Colonel, Medical Corps  
Editor-in-Chief

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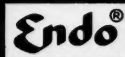
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## BOOK REVIEWS

**YOUR CHILD'S CARE. 1001 QUESTIONS AND ANSWERS.** A Mother's Guide to Healthy and Happy Babies by Harry R. Litchfield, M.D., F.A.C.P. and Leon H. Dembo, M.D. Doubleday & Company, Inc., Garden City, N.Y., 1960. \$3.95

This book is helpful to those who would like to follow the progress of their child growing up. Information is basic and functionally adequate to relieve most parents' anxieties. In addition to the common childhood problems, special attention has been given to such topics as the Rh factor, congenital and acquired heart disease, immunizations, congenital deafness, muscular dystrophy, nephrosis, allergies, cystic fibrosis, cerebral palsy, cancer and diabetes in childhood. The chapter on poison is good.

On page 32, a multiple four-way vaccine, combining whooping cough, diphtheria, tetanus and polio, is mentioned. As presently available, this four-way vaccine lacks satisfactory potency as regards its pertussis component. It is recommended that all children who have received this four-in-one vaccine be re-immunized promptly against pertussis. On page 35, oral polio vaccine is said to be not licensed yet. It is now licensed and will soon be available. On page 107, the incubation period for scarlet fever is stated to be 2-4 days. It may be a few hours to as much as 6-7 days and carditis can be added to the list of scarlet fever complications already noted in the book.

This manual is recommended for parents. It should help to cut down on unnecessary telephone calls to doctors but not serve as a substitute.

PETER L. MATHIEU, JR., M.D.

**THE LIST METHOD OF PSYCHOTHERAPY** by Elizabeth Sher, Eleanor Messing, Theodora Hirschhorn, Enis Post, Annette Davis, and Arthur Messing with an introduction by Jacob S. List. Philosophical Library, New York, 1960. \$7.50

This 257-page book consists of about thirty to fifty pages by each author. Sher discusses *Therapist Selection and Training*; Eleanor Messing, *Higher Education as Therapy*; Hirschhorn, *The Reception Room as Therapeutic Community*; Post,

*Family Resistance and Client Progress*; Davis, *Warmth in the Therapeutic Process*; and Arthur Messing, *Sexual Inversion and Re-orientation. The Reception Room as Therapeutic Community and Higher Education as Therapy* are stimulating chapters. The reception room is used to promote friendliness and social contacts; and higher education to get patients to take their minds off their problems, to allay anxiety, and to promote different goals.

Success in higher education tends to increase self-respect, social relations, ability in self-expression, and appreciation of self-value. It makes anxiety less important and decreases self-preoccupation. Concentration is on talents and ability rather than on failings and inferiority feelings. The patient is turned from thought to action. This probably accounts for much of the success of the treatment. Education is aimed at intellectual maturity. The accompanying psychotherapy is aimed at emotional maturity which is so necessary to secure the acceptance of the discipline of education.

WILLIAM NEWTON HUGHES, M.D.

**THE MODERN FAMILY HEALTH GUIDE.**

Edited by Morris Fishbein, M.D. Doubleday & Company, Inc., Garden City, New York, 1959. \$7.50

This volume contains one thousand and one pages. The first four hundred are divided into ten parts, descriptive writing about various phases of medicine, by a large staff of contributing specialists. Included are some general remarks about health and modern medicine by the editor; problems of infancy, childhood and adolescence; diseases of most of the major systems; sections on "the later years," medical statistics and first aid. The last six hundred and one pages contain an *Encyclopedia of Family Health* and an index. The encyclopedia contains definitions of diseases, drugs, anatomical parts and assorted medical terms. Often there is quite a long discussion, as in the liver entry, which merits two full pages. This includes anatomy, physiology, pathology, clinical entities and treatment, all in a nutshell.

The last forty pages contain a very complete index of everything mentioned in the book, which covers a lot of territory. The index is thorough,

*continued on page 14*

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## BOOK REVIEWS

continued from page 12

and adds greatly to the volume as a ready reference.

One wonders about the usefulness of this tome, obviously produced with great effort. It may have value as a reference for minor illnesses and accidents, and family discussions about medical subjects. For some households it may be true that "a little medical knowledge is a dangerous thing," and here damage could be done. With the rapid changes in medicine today, much information will be quickly outdated, requiring careful revision.

In summary, this is a notable effort to provide a "household guide" to health and medical problems. It contains a wealth of information, but should be recommended for home usage with definite reservations.

ROBERT W. DREW, M.D.

*THE RELUCTANT SURGEON.* A Biography of John Hunter by John Kobler. Doubleday & Co., Inc., Garden City, N. Y., 1960. \$4.95

For the reader with an interest in medical history, John Kobler's biography of John Hunter is highly recommended. The author presents a thorough study of the life and times of the "founder of scientific surgery."

In addition to the accounting of Hunter's many original exploits in all branches of science, one is presented with an excellent picture of life in England during the eighteenth century. Of special interest are the accounts of the profound effects that both John Hunter and his brother William had on the development of American medicine. Several early American surgeons and physicians traveled to England to study with these great teachers. Upon their return to this country many of these men made great contributions to the growth of medicine here. One of these, Doctor John Morgan, founded the country's first medical school at the University of Pennsylvania. Of interest to local readers is the story of Doctor Benjamin Waterhouse, a Rhode Islander by birth, who in 1775, after serving an apprenticeship in medicine at Newport, traveled to

## RHODE ISLAND MEDICAL JOURNAL

London to study with John Hunter. Doctor Waterhouse's major contribution to medicine in this country after his return was the introduction of vaccination.

Apparently, John Hunter has been neglected by biographers in the past. In his preface to *The Reluctant Surgeon*, the author states that his work is "an effort to reclaim the scientist from the archives and the man from the shadows." I feel that he has successfully accomplished this purpose.

BANICE M. WEBBER, M.D.

*WHAT PRICE MEDICAL CARE? A PREVENTIVE PRESCRIPTION FOR PRIVATE MEDICINE*, by the author of the Australian National Health Plan, a former Prime Minister for Health of Australia, Doctor the Rt. Hon. Sir Earle Page. J. B. Lippincott Company, Phil., 1960. \$3.50

In this book of 160 pages, Sir Earle Page, who is a surgeon with half a century of practice behind him, a member of the Australian Commonwealth Parliament, has served his country as Acting Prime Minister, Commonwealth Treasurer, Minister of Commerce, and Minister for Health, and has been Chancellor of the University of New England in Australia since its founding, presents a most lucid exposition of the Australian Medical Plan, which became the law of the land in 1953. This book is unique, and of extraordinary practical interest and importance because it deals not so much with theories as to what should be done, but with what has been done, has been tested by time, and has been successfully applied to the problems of medical economics in a country similar in many ways to the United States. It deals with the ways and means whereby Australia has met the same challenge that faces the American people.

There is a particular and urgent reason for the writing and publishing of Sir Earle's book about medical problems and the Australian formula for their solution. Medicine in the United States needs help. It needs help, and it needs it now, because ordinary and conventional approaches to the financing problem of people needing medical and hospital care will no longer meet an urgent public need. Hackneyed slogans about the sanctity of "free medicine" or the iniquities of so-called socialization will not help either. Campaign promises in an election year may hurt more than they help, if they hurry the American people into an ill-considered solution for the course of medical care.

In these pages Sir Earle emphasizes the need for co-operation of all concerned with public health and public welfare. They include hospital administrators, trustees, insurers, those who write for newspapers and edit them, employees and their union officials and representatives, and those occu-

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pled in government in all phases. Doctors especially will be obliged to learn to work together if the United States is to avoid the pattern of governmental medicine now dominant throughout the world except in the United States and Australia.

E. A. van Steenwyck, executive vice president of the Associated Hospital Service of Philadelphia, made the following pertinent comments in his introduction to this little, but important book:

"Despite all our progress in voluntary insurance against medical expenses in the United States, the most insistent questions remain unanswered. They include questions about the degree of coverage and extent of coverage for average income Americans, and the particular medical problems of older people and the repetitively ill. There is no satisfactory formula as yet to establish an appropriate relationship between government and the insuring groups or agencies in protecting all the people against crippling expenses for medical services. As providers of the services, hospitals and doctors have not yet found a common ground of co-operation. . . .

"Everyone knows what he wants in the way of medical care; he wants the best. Everyone also acknowledges that what he wants for himself and for his family ought to be available to all, whether they are able to pay or not. No price-tag can be put on health, but no plan for the nation's medical care is sound which lessens incentive to scientific progress or sacrifices the freedom of patients and physicians in the name of expediency. A common incentive is needed to resolve and consolidate these conflicts of interests and purposes. Sir Earle has contrived a plan which appeals to all the parties concerned and is approved by all. It solves the public problem, yet keeps medicine in Australia free from government domination. This, above all, makes the story important to Americans at this time." The basic features of the plan are explained and concern themselves with hospital care, medical benefits, the cost of drugs, and preventive medicine. Without going into too much detail, the essential points of each portion of these plans are worth mentioning in this review.

The hospital benefits scheme provides benefits to all qualified patients in approved hospitals. The Commonwealth provides what is called the "ordinary hospital benefit," paid on a per diem basis for patients in approved hospitals. This amounts to about 40 per cent of the cost of providing hospital care. In addition, under the plan, the Commonwealth supplements the ordinary benefit by an additional payment, amounting to half the ordinary benefit, for patients in approved hospitals who are also members of hospital insurance organizations registered for this purpose. The hospital insurance organizations are required to pay benefits from their own funds. These benefits may vary accord-

ing to the rates of contribution by their members, and in some cases they provide benefits to meet the hospital charges in a particular state, but they must meet the minimum requirements in order for their members to be eligible for the supplementary payments made by the Commonwealth, over and above the ordinary hospital benefits. A certificate of hospitalization is presented to the patient who presents it to the private insurance organization. The organization pays the additional benefit on behalf of the Commonwealth as well as its own benefit and is then reimbursed by the Commonwealth. The effect of this plan is to provide continuous revenue to hospital managements. This in turn assures the provision and improvement of hospital services.

The general objective of the medical benefits plan is to "insure that everyone in Australia who makes provision through insurance will be able to cover the major cost of all surgical and medical attention, whenever or wherever sickness or accidents occur." To qualify for the benefit the patient must be a financial member of an approved medical insurance organization. The Commonwealth government will provide financial support of voluntary insurance against the cost of medical attention. The government's aim is that its subsidy, plus the payment from the private organization, should cover the major portion of the doctor's charges. The amounts

*continued on next page*

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of the benefits or subsidies that the government will pay are set out in a table of subsidies, covering every known medical service, treatment or procedure. The amount varies in relation to the nature of the medical service, but for any particular service it remains the same, whatever actual fee the doctor charges, or whether the service is rendered by a general practitioner or specialist. The government will not try to interfere in the administration of the private insuring organizations, though they will grant approval only to an organization that complies with certain minimum requirements and conditions, which are designed to protect the members. The approved insurance organizations will be free to decide for themselves whether the benefits, including the Commonwealth subsidy, will be paid directly to the member when he produces a receipted account from the doctor, or directly to the doctor on the authority of the member who presents an unpaid account. An important objective of the plan is to achieve stability in medical charges, so that insured patients may have some measure of certainty as to what their illness or injury will cost. In this manner the Australian medical profession has set a splendid example of restraint and good sense, though without impairment of professional rights or privileges. The doctor decides whether the patient should be admitted to a hospital and when he should be discharged. A reasonably constant scale of charges by physicians has been established, not by the *government* but by the doctors themselves. This is necessary in order to stimulate membership in the insured societies, which would be unable to guarantee adequate benefits to their subscribers if the doctors' charges varied over too wide a range. Actually each doctor is free to charge what he pleases, with due regard to what the patient is able and willing to pay, which may exceed, more or less, the benefits provided by his insurance. Obviously overcharges and other abuses are not subject to government intervention or control; *the doctors regulate and discipline themselves.*

Another very important feature of the Australian plan is the making available of "life-saving medicines" at a nominal charge at the Australian drug-store. A list of proved life-saving and disease preventing medicines have been selected by an advisory committee of expert medical specialists who may also recommend the exclusion or inclusion of specific remedies. Any qualified medical practitioner in Australia can prescribe or order these medicines. Excluded from the "free" list are some items that are mostly used for self-medication, or for trifling indispositions that do not need a doctor's care. The Australian plan does not want its people to become chronic pill-takers for every unimportant or imaginary ailment, as have many hypochondriacs in countries which have made all medicines free to

the consumer.

In facing the problem of abuses of this system which requires the co-operation of the patient, the doctors, the hospital administrators, and the druggists, the National Medical Plan calls for the creation of a medical service committee, sometimes referred to as a "Supreme Court of Medicine," consisting entirely of doctors of unquestionable competence and integrity. The members are appointed by the Minister of Health from panels nominated by the British Medical Association of Australia. Cases of suspected irregularity or abuse on the part of doctors are referred to the committee by the Director General of Health. The committee then examines each case and gives the doctor the opportunity to be heard personally. If it is found that the doctor has failed to observe proper standards, appropriate punishment is recommended to the Minister. This punishment may be severe, even resulting in the withdrawal of the offender's right to receive payment from the insurance fund for his services. Experience has shown that the very existence of the committee, together with another representing the druggist, is an invaluable check on abuse. Experience also shows that the percentage of cases requiring disciplinary action by the committee is extraordinarily small. The overwhelming majority of doctors co-operate in the conduct of the Australian medical plan without any suggestion of irregularity.

A study made by a group of consultants concerning welfare, health, and pension programs in the United States stated: "Some doctors increase their fees in direct proportions to the amount of insurance money available. They include the insurance money as part of the ability to pay—and go on from there." Be that as it may in the United States, the Australian believes that it is far better for the medical profession to put its own house in order, rather than await the inevitable and heavy-handed interference of government when medical costs get too much out of line. Thinly veiled threats of such regulatory action have appeared in American periodicals, and the theme of governmental control of medical earnings may become a punching bag of politics in the United States, as is already the case in respect to the cost of certain medicines. We agree with Sir Earle when he states that there may be temptation to follow the lead of other countries into the pitfalls of socialized medicine, but there is a far more inspiring opportunity to find a better, wiser way to solve our problems. He continues: "Borrow from the Egyptians all you can use, as the Israelites did when they escaped to the wilderness in the Promised Land. Borrow advice and warning from those who have tried other systems of medical planning and discover their dangers and weaknesses. Borrow from Australia, if you please,

our experience with the plan which has worked well and smoothly for years and may be made to work even better in a bigger, richer country. We in Australia have borrowed and learned much, so much from you; we will be proud and happy to lend you something of our own.

"But whatever and whenever she may borrow, America's world leadership in medicine is secure if she remembers and defends the principles which made her a nation while Captain James Cook was still feeling his way along our coastline. It was nearly twelve years after the Declaration of American Independence that the first British colony was founded at Botany Bay and an Australian history began. Now the world of medicine awaits to see what the Americans will do. In 1776 freedom and independence were the paramount issues in politics and the theory of government, as they are today in medicine."

Sir Earle has stated that this book is his effort to repay a debt that he owes to the United States. If we learn what he is trying to teach us it will be ourselves who will forever be in his debt.

STANLEY D. SIMON, M.D.

#### CURRENT SURGICAL MANAGEMENT II.

A Book of Alternative Viewpoints on Controversial Surgical Problems. Edited by John H. Mulholland, M.D., Edwin H. Ellison, M.D., and Stanley R. Friesen, M.D. W. B. Saunders Company, Phil., 1960. \$8.00

At the outset, one should say that CURRENT SURGICAL MANAGEMENT II is considered worthwhile and rewarding reading. The following topics are discussed: duodenal ulcer, polyps of the colon, diaphragmatic hernia, pancreato-biliary surgery, pilonidal sinus, carcinoma of the breast, intestinal obstruction, arterial insufficiency, thromboembolism, renal failure, colon preparation for surgery, and prolapse of the rectum. Each section is presented by an authority in his field. Representative viewpoints are submitted where controversy is said

to exist. The articles are not bogged down in detail by case reports, lengthy statistical quotations, or experimental data. They are more narrative in type, resembling panel discussions so popular at surgical meetings.

In the book, as at the meetings, there is reason to believe that the word "controversy" has been overworked. One of the editors, Dr. Mulholland, introduces the "controversy" concerning common duct stones by saying, "There is no present-day controversy about the desirability of removing all stones..." Dr. Baker and others describe their satisfactory experience with operative cholangiography. Dr. Ferris, in presenting his case for the detection of common duct stones by means of surgical exploration, states the alternative viewpoint, or the other half of the "controversy," and says that no single finding or maneuver detects common duct stones infallibly, and that the surgeon must utilize every means available. Dr. Ferris, incidentally, has always been a principal protagonist for operative cholangiography at the Mayo Clinic. Complementary, indeed, coinciding viewpoints thus have somehow been fitted into a format of controversy. Perhaps the injection of the element of controversy stimulates added interest to a given problem.

The book is attractively printed and bound, and contains 348 pages. The type is pleasantly legible. There should be no controversy about recommending CURRENT SURGICAL MANAGEMENT II.

J. E. CARUOLO, M.D.

#### LIBRARY HOURS

DAILY (except Saturday and Sunday)

8:30 A.M. — 4:30 P.M.

#### BENEFIT PAYMENTS BY INSURANCE COMPANIES

During the first nine months of 1960 some \$2,342 million in health insurance benefits were received by Americans from the nation's insurance companies. This was an increase of eight per cent over the same period in 1959. A distribution of benefits according to type of coverage for the first nine months of 1959 and 1960 follows:

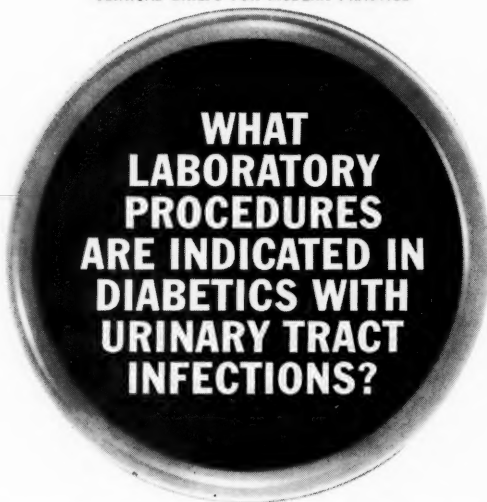
Type of Coverage	9 months 1960	9 months 1959	% increase
	(in millions of dollars)		
Hospital Expense*	\$ 933	\$ 853	9.5%
Surgical Expense*	321	312	3.1
Regular Medical Expense	88	80	9.4
Major Medical Expense	309	243	26.8
Loss of Income**	691	680	1.6
TOTAL	\$2,342	\$2,168	8.0%

\*Excludes benefits for hospital and surgical expenses received by major medical expense policyholders.

\*\*Includes accidental death and dismemberment benefits.

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Source: Harrison, T. R., et al.: Principles of Internal Medicine, ed. 3, New York, McGraw-Hill Book Co., 1958, p. 620.

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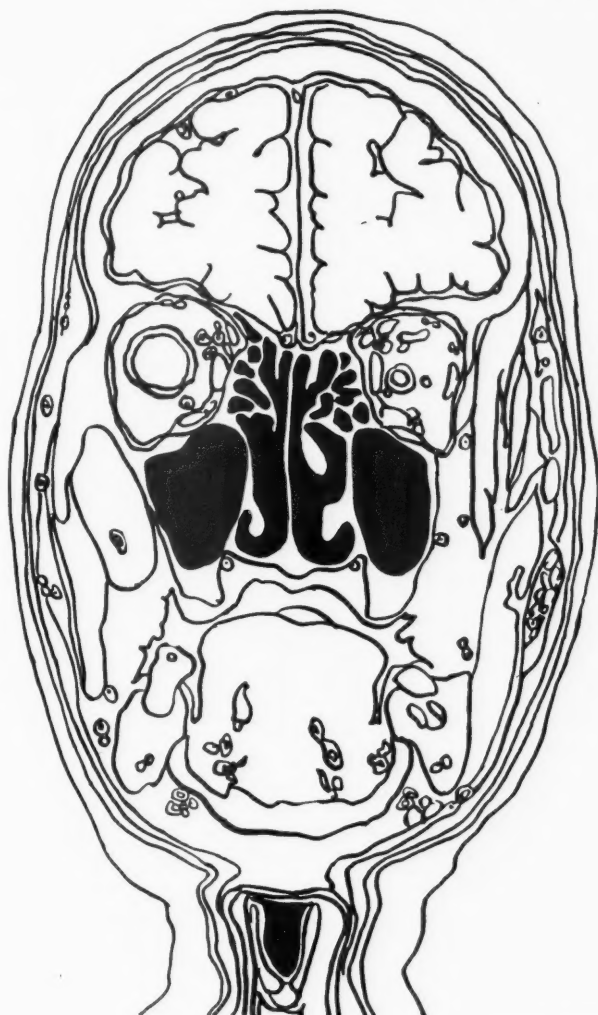
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## THE WASHINGTON SCENE

### A Summary Report Prepared by the Washington Office of the American Medical Association

PHYSICIANS ARE BEING URGED to co-operate fully to get their states to participate as soon as possible in the new federal-state program for medical care of needy and the near-needy older persons.

The medical profession also has been alerted to the dangers of relaxing its opposition to tying in medical care of the aged with Social Security. It is probable that the Kennedy Administration will try in 1961 to get Congressional approval of such legislation.

E. Vincent Askey, M.D., president of the American Medical Association, pointed out to the recent Washington meeting of the A.M.A. House of Delegates that proponents of the Social Security approach had a pledge of support from the successful Democratic candidate for President.

"While our profession clearly may face a hard struggle in the 87th Congress on the issue of medical aid for the aged under Social Security, there is no ground for defeatism!" Dr. Askey said.

"Our cause is far from lost. We know that our policy position is in the best interests of all Americans, the aged included, and our willingness to defend this policy must be strengthened and maintained."

Doctor Askey reminded the House of Delegates that "medicine has many friends in both parties in Congress today."

A few days later, Sen. Harry F. Byrd (D., Va.), chairman of the Senate Finance Committee which handles Social Security legislation, reiterated his opposition to a compulsory medical care plan under Social Security. He said:

"I am opposed to the (Democratic party) platform recommendation for compulsory medical service and hospitalization under the Social Security system. I am convinced this would lead to socialized medicine with the possibility that it would bankrupt the Social Security trust fund. This matter came before the Finance Committee and was fought out in the post-convention session of Congress last August. The Senate voted 51 to 44 in opposition to the Democratic platform proposal, and instead adopted a fair plan for medical service and hospitalization for those in need of it."

Doctor Askey urged that all county and state

medical associations provide "the medical leadership necessary to implement the Mills-Kerr bill (the new federal-state program) as rapidly as possible." And the House of Delegates adopted such a resolution.

"We must put forth a sincere and concentrated effort during the coming year to make the Mills-Kerr law effective, to show that it can, practically as well as potentially, solve the problem of medical care for the aged," Doctor Askey said.

President-elect John F. Kennedy's first Cabinet appointment was Governor Abraham Ribicoff of Connecticut as secretary of Health, Education and Welfare — the official with primary responsibility for carrying out the federal part of the Mills-Kerr program.

Ribicoff, fifty, was an early supporter of Kennedy for the Presidential nomination. He was twice elected governor of Connecticut. Before that, he served as a Hartford, Conn., police judge, a member of the state legislature and a member of the national House of Representatives. As governor, he inaugurated a comprehensive traffic safety program with strong penalties.

\* \* \*

The Sabin oral polio vaccine will not be available in sufficient quantity in 1961 for large scale use.

Leroy E. Burney, M.D., surgeon general of the U.S. Public Health Service, told the recent clinical meeting of the A.M.A. that many problems involved in taking the oral vaccine out of the laboratory and into mass production had not been solved.

In light of this fact, both the A.M.A. House of Delegates and Doctor Burney urged that the widest possible use of the Salk vaccine be encouraged. Doctor Burney said that large numbers of the U.S. population, including almost half of the children under five, had not been fully vaccinated with the effective Salk vaccine.

Doctor Burney said the problems of integrating the oral vaccine into the present program of immunization against polio "are many and complex."

"Only the future can tell whether control of poliomyelitis will be accomplished through a live,

*concluded on page 21*



## THE WASHINGTON SCENE

*concluded from page 20*

orally administered vaccine, the killed vaccine, or a combination of both," Doctor Burney said.

\* \* \*

The Food and Drug Administration issued stricter rules, some effective January 8 and others effective March 9, governing promotion and marketing of prescription drugs. The new regulations are designed to insure safe use of the drugs.

Under the new regulations, manufacturers must disclose hazards, as well as advantages, of the drugs in promotional material sent to physicians. Manufacturers can be denied permission to market drugs they refuse to permit FDA inspection of manufacturing methods, facilities, controls or records.

The FDA deferred until later action on its proposal to require every package of drugs sold to pharmacies to contain an official brochure on their use and hazards. The A.M.A. proposed instead that it be given the responsibility of getting such information directly to physicians.

\* \* \*

Foreign interns who failed medical examinations last September may remain in this country until at least next July 1.

In co-operation with the State Department, the A.M.A. agreed to extend for six months a January 1 deadline for dismissal of foreign interns unless they pass the examinations through the Educational Council for Foreign Medical Graduates.

The flunking interns will be given another opportunity to take the examinations in April. Meantime, they must be taken off patient care and their hospitals must set up training programs for them.

The A.M.A. Council on Medical Education and Hospitals, said that this policy would be carried out judiciously and that occasional exceptions would be granted where circumstances warranted.

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## Progress Notes . . .

### MANAGEMENT OF THORACIC TRAUMA\*

PAUL C. ADKINS, M.D.

The Author, Paul C. Adkins, M.D., of Washington, D. C. Associate Professor of Surgery, the George Washington University School of Medicine.

**I**NJURIES to the thoracic cage and its contents are an everyday occurrence in this modern age. An understanding of the alterations in physiology which occur as a result of such injuries are essential for logical management and ultimate survival of the patient. The objective of management of thoracic injuries is restoration of cardiopulmonary function to normal as quickly as possible. Basically, this involves restoration of a normal circulating blood volume and adequate oxygen supply to all body tissues. Experiences in World War II and subsequent years have indicated that, in the vast majority of instances of injury to the thoracic viscera, early thoracotomy is unnecessary and may be harmful; other, more simple measures in the early management of these cases yield far more satisfactory results.<sup>4,5</sup> These measures are termed resuscitation and involve early recognition of the patient's condition, treatment of shock, maintenance of an open airway, management of sucking wounds of the thorax, recognition of hemothorax and pneumothorax, and relief of pain and anxiety. During this early phase of therapy, typing and cross-matching of blood, intravenous fluid therapy, and roentgenograms of the chest may be accomplished. After these have been carried out, and full evaluation of the situation made, decisions can be then made regarding the necessity for subsequent surgical management.

Trauma does not respect anatomical barriers, and in many instances multiple injuries are present. Nevertheless, restoration of cardiopulmonary function is the prime objective, and immediate survival is dependent upon achieving this objective. Once this has been accomplished, efforts may then be directed towards management of injuries of the abdominal viscera, neurosurgical problems, and fractures. More often than not, particularly where

several individuals are involved in an accident or other form of catastrophe, varying numbers of physicians, surgical specialists, house officers, and other personnel may be involved in the resuscitative effort. It is essential under these circumstances that one individual assume the responsibility of direction of the effort, determination of priority of treatment, and co-ordination of varying phases of management. In other words, when there is a team effort there must be a captain, and it makes little difference who this is as long as everyone recognizes his direction. Without this, well-intentioned but unco-ordinated efforts may result in unnecessary delay and even loss of life.

Regarding evaluation of the patient, the initial appearance may be extremely misleading. Small, almost insignificant stab wounds with no other signs of external violence may cause disastrous changes in the vital mechanisms. On the other hand, the patient who is cyanotic and in shock often may be resuscitated by a few relatively simple measures. This is especially important in the busy emergency room where minimal signs of external violence may be overlooked with disastrous consequences.

In order to achieve adequate resuscitation, a knowledge of the essential components of the cardiopulmonary mechanism is necessary. These include: 1. adequate circulating blood volume, 2. an intact chest wall, 3. an open airway, 4. maximum expansion of the lungs, and 5. normal intrapleural pressures.

Although alterations in most of these factors will overlap in any type of trauma, for purposes of discussion they will be covered separately.

#### *Shock*

The classical clinical manifestations of shock, the underlying pathophysiology, and general principles of management are well known, so will not be discussed. It should be pointed out, however, that hidden blood loss is a very common occurrence in trauma. Splenic rupture is a frequent companion of injuries of the left lower chest and must always be considered. Intrathoracic bleeding will be dis-

*continued on next page*

\*Read at the John F. Kenney Memorial Clinic Day, at the Memorial Hospital, Pawtucket, Rhode Island, on November 2, 1960.

cussed subsequently. Early and adequate transfusions for patients with blood loss are an essential part in the resuscitative effort.

On the other hand, partial suffocation may play an important role in the shock picture. Consequently, when inadequate air exchange is present, early efforts at restoration of an open airway may be the most essential portion of the management. In the patient with major thoracic trauma, the traditional Trendelenburg position used in the treatment of shock may actually be harmful, since it places weight on the diaphragm and interferes with its function. The semi-Fowler's position with maximum opportunity for diaphragmatic motion is preferable. This is also the position of choice for transportation of the patient with thoracic injuries. If prompt clearing of the airway is not obtained by suction, early tracheostomy should be performed.

#### *Simple Chest Wall Injuries*

A fractured rib may be termed a simple injury, and it often is in a young robust individual. However, if this occurs in an aged or debilitated person it may become quite complex. Chest wall pain, as a result of the fracture, with diminution of excursion of the involved side of the chest, diminished ventilation, subsequent atelectasis and possibly pneumonia and severe embarrassment of pulmonary function may result (Figures 1, 2). Strapping of the chest is not a very effective method of immobilization of the chest wall and is mainly of psychological value. Circumferential wrapping of the thoracic cage is a more efficient method of immobilization, but may also significantly interfere with ventilation. Thus if circumferential wrapping is to be used, the patient must be checked carefully for any signs of respiratory embarrassment. Restoration of an efficient cough mechanism is essential to avoid atelectasis and its accompanying problems which are frequently associated with the painful rib fracture. Probably the most satisfactory method of management is intercostal nerve block which relieves the pain and allows the patient to cough efficiently. Drugs which may depress respiratory function or significantly interfere with the cough mechanism should be avoided in the management of these problems.

The rib fracture with separation of the fragments may result in a laceration of the intercostal vessels accompanying the rib with consequent bleeding or may cause an injury to adjacent pulmonary tissue, resulting in hemothorax, pneumothorax, or both (Figure 3). When a pulmonary laceration occurs in an area where the lung is stuck to the chest wall, considerable subcutaneous emphysema may ensue.

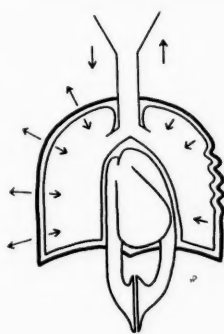
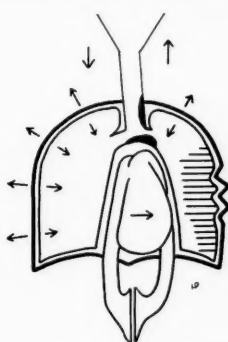
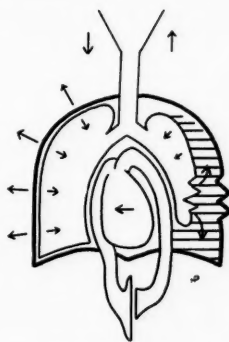
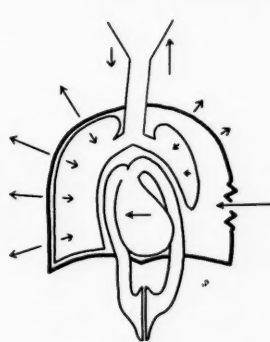
Another consideration in chest wall injuries is that situation where there are multiple rib fractures, resulting in the so-called "flail chest." This type of injury of the ribs or the sternum is a frequent consequence of auto accidents and abrupt contact with the steering wheel. In this situation there is marked paradoxical motion of the involved portion of the thoracic cage with resultant reduction in the function of the underlying lung. In addition, there is severe pain and loss of an effective cough mechanism. This usually results in the "wet lung syndrome" in which there is not only blunt trauma to the involved lung but retention of secretions as well. It was Doctor Noland B. Carter<sup>6</sup> who first pointed out the effectiveness of tracheostomy in this situation. In a flail chest injury, early tracheostomy has several benefits:

1. It reduces dead space of the upper respiratory system, resulting in more efficient ventilation.
2. It enables the physician or nursing staff to perform simple and frequent tracheal aspirations to get rid of secretions.
3. It reduces resistance by bypassing the upper air passages, consequently reducing the amount of change in pleural pressures in order to achieve adequate ventilation. This consequently reduces the amount of paradoxical motion of the chest wall.

In addition to tracheostomy, intercostal nerve block of the involved rib areas diminishes the accompanying pain. External traction of the paradoxical area of the chest wall is rarely necessary, and generally if a tracheostomy has been performed a little mild pressure to reduce paradox is preferable. In the patient with other severe injuries, particularly a head injury, or the patient who is exhausted and unable to achieve adequate respiratory exchange, a mechanical ventilator which has a positive and negative phase may be attached to the tracheostomy to maintain adequate air exchange.<sup>2</sup>

#### *Penetrating Wounds*

Penetrating wounds of the chest wall may vary from a minute stab wound, produced by an ice pick, to a large sucking wound with considerable loss of tissue. When there is a sucking wound of the chest wall, air rushes into the pleural space causing collapse of the lung on the involved side (Figure 4). In addition, this pushes the mediastinum to the opposite side causing further reduction in the vital capacity. On expiration, the mediastinum swings back towards the involved side, and this phenomenon, known as "mediastinal flutter," still further reduces ventilatory ability. Mediastinal flutter also interferes with cardiac filling with consequent reduction in cardiac output

**PAIN****FIGURE 1****ATELECTASIS****FIGURE 2****Hemothorax****FIGURE 3****PNEUMOTHORAX****FIGURE 4**

and interference with the circulatory mechanism.

The management of sucking wounds of the chest consists first of conversion from an open to a closed wound. This may be accomplished by the use of Vaseline® gauze, adhesive tape, or any kind of dressing which may be available, even a hand in the case of emergency. It is important to remember that, if dressings or packing are used to close the open wound, they should not be stuffed into the pleural space, since they may interfere with re-expansion of the lung.

#### ***Pneumothorax***

The presence of air in the pleural cavity or in the pleural space alters the intrapleural pressure from its normal slightly negative level to an atmospheric or positive level. This results in shift of the mediastinum towards the opposite side. The objectives in treatment are removal of the air from the pleural space, full re-expansion of the lung, and restoration of normal negative intrapleural pressures. One often hears the term "tension pneumothorax." The term "progressive tension pneumothorax" is preferable. This implies that pressure is building up, due to continued leakage of air into the pleural space causing increased positive intrapleural pressure and further shift of the mediastinum towards the opposite side with resultant interference with the function of the opposite lung. Simple aspiration of air from the pleural space using a needle and syringe may be adequate if there is no injury to the visceral pleura or lung parenchyma. However, in thoracic trauma, if a pneumothorax is present, there is frequently injury to the lung itself. Under these circumstances, we prefer to achieve re-expansion of the lung by use of a catheter placed in the pleural space through an intercostal stab wound and attached to water seal drainage. This catheter should be placed high anteriorly, preferably in the second interspace in

the anterior axillary line. It is placed there so that, with the patient in the semi-Fowler's position, air will usually rise to the uppermost portion of the pleural space. Thus this is an optimum position to drain all the intrapleural air. Catheters that are placed lower down will generally achieve only partial re-expansion of the lung. Simple water seal drainage is generally sufficient unless there is a large parenchymal tear, and the patient is losing more air through the tear in the lung than the catheter is able to evacuate. Under these circumstances, water seal suction is utilized to evacuate the air as rapidly as it is given off.

Once a catheter has been inserted in the second interspace anteriorly and attached to water seal drainage, the lung should re-expand rather promptly. If this does not occur, and the patient continues to blow large amounts of air into the water seal bottle, the possibility of injury to a major bronchus or to the trachea must be considered. This may be confirmed by bronchoscopy, which will also localize the site of injury. Once this diagnosis has been established, early thoracotomy and repair of the tracheal or bronchial laceration is imperative.<sup>7</sup>

#### ***Hemothorax***

Bleeding into the pleural space may come from either the systemic or pulmonary vessels. The most frequently injured systemic vessels are the intercostal vessels or the internal mammary vessels. Bleeding from the pulmonary parenchyma may be either from pulmonary arterial or pulmonary venous sources. Since the pressures in the pulmonary system are low, fatal hemorrhage from pulmonary lacerations is uncommon. On the other hand, bleeding from the systemic vessels may be quite large and usually requires rather prompt intervention. Generally a hemothorax is associated with a penetrating wound but may be also due to

*continued on next page*



blunt trauma. Unless the bleeding is obviously severe and requires immediate operative intervention, the general plan of management is to aspirate the blood. Aspiration should be done at a dependent level, and as much blood as possible should be removed. There has been some notion that early aspiration might provoke further bleeding. This has proved to be untrue, and early aspiration of all blood is essential for restoration of normal cardiopulmonary function as well as an initial resuscitative effort. Should rapid re-accumulation of blood occur, the bleeding is probably from a systemic vessel or major pulmonary vessel, and surgical intervention is indicated.

The use of fibrinolytic enzymes in the management of hemothorax has been advocated, but our experience with this has generally not been satisfactory, especially when there is known trauma to the lung or visceral pleura. We have seen at least five broncho-pleural fistulae which were probably associated with the use of these enzymes. Catheter drainage of a hemothorax alone is not advisable since the probability of infection of the blood in the pleural space is great, with the consequent problems of empyema. When a hemothorax and pneumothorax are present together, decompression of the pneumothorax by a catheter attached to water seal drainage and needle aspiration of the hemothorax is the preferable method of management.

#### *Cardiac Wounds*

Wounds of the heart are usually the result of penetrating injuries of the chest wall, either by knives or other missiles. On the other hand, blunt injury to the anterior chest wall may result in major injury to the heart itself with hemopericardium and cardiac tamponade. This possibility should not be overlooked, particularly in steering wheel injuries, as the manifestations may not develop until several hours or even more after the initial injury.

Considering penetrating injuries of the heart, one of three things may occur. The first is that the injury may be so slight that no serious changes in the cardiac mechanism may be incurred. Secondly, the patient may die immediately, generally as the result of injury to the conduction bundle or to a coronary vessel. Thirdly, bleeding may occur into the pericardial sac (less commonly into the pleura) and cardiac tamponade may occur. The patient does not die immediately; there may be a latent period when the patient gets over the initial shock of the injury and gets up and thinks that he is all right. Then, within thirty minutes to an hour, weakness and syncope may occur as a result of the bleeding into the pericardial sac. It is in this situation that the alertness of the physician is essential

in saving the patient. The classical triad of Beck for acute cardiac tamponade is an increased venous pressure, a narrow pulse pressure, and a small quiet heart.<sup>3</sup> Of these signs, the small quiet heart is the least reliable, since we have seen patients in frank cardiac tamponade with easily audible heart sounds. If cardiac tamponade is suspected, aspiration of the pericardial sac is essential. When bleeding occurs rapidly, a few hundred cubic centimeters may be quite sufficient to cause marked interference with venous filling of the heart and produce all the manifestations of tamponade. Aspiration of as little as thirty or forty cubic centimeters may be sufficient to relieve the acute pressure and revive the patient. Pericardial aspiration is preferably performed through the subxyphoid route, although the apical route may be utilized. If the diagnosis is in question and there is sufficient time, a venous pressure determination may be made; fluoroscopy of the heart may be helpful in ascertaining the presence or absence of visible pulsations, and an electrocardiogram may demonstrate marked diminution in the voltage of the tracing.

Simple pericardial aspiration is generally successful in relieving the immediate effects of tamponade by removal of some blood. There is some difference of opinion about subsequent management of cardiac tamponade as a result of a stab wound, however. The work of Blalock and Ravitch<sup>2</sup> indicated that the majority of these patients could be managed without operation, simply by one or repeated aspirations of the pericardial sac. On the other hand, it is generally our present policy, if, after the first aspiration, evidences of tamponade recur and repeat aspiration does not immediately relieve them that thoracotomy is necessary. In the past several years, we have more frequently resorted to thoracotomy in the management of hemopericardium since it is virtually impossible to remove all the blood by simple aspiration. If most of the blood is not removed, many of these patients may subsequently develop organization and constrictive pericarditis. The incision is generally made in the fourth or fifth left interspace anteriorly with division of the costal cartilage. This affords adequate exposure of most of the anterior surface of the heart. If, however, the wound is definitely on the right side, we would generally approach the heart through a similar incision in the right chest. Once the pericardium has been opened and the site of injury exposed, bleeding can be controlled by the finger while sutures are placed beneath the finger to approximate the myocardium. In the vast majority of instances in which open operation has been performed, we have been glad that we did so either from the nature of the injury or from the amount

of residual blood in the pericardial sac.

### *Injuries of the Esophagus*

Wounds to the esophagus from external trauma are rare since this is a well-protected structure. A great majority of esophageal wounds are caused by internal violence from endoscopic examination. The most common sites of injury are the cervical esophagus and the lower third of this organ. Esophageal laceration may be suspected by the nature and location of the injury and is confirmed by a swallow of radiopaque material. For this purpose, Dionisil® is preferable to barium. Esophageal perforations are usually accompanied by mediastinal or subcutaneous emphysema or hydropneumothorax. Generally there is severe chest pain particularly in the substernal region. If the diagnosis is made sufficiently early, the treatment of choice is definitive closure of the laceration. This must be accomplished within the first twenty-four hours after injury, since suture of the esophagus after this period is virtually impossible because of the accompanying tissue reaction. If the diagnosis is not apparent or if definitive treatment cannot be instituted in the first twenty-four hours, simple drainage of the area is preferable. In the case of the cervical esophagus, the retrovisceral space must be drained, and in the case of the intrathoracic esophagus, wide drainage of the pleural space is essential.<sup>1</sup>

### *Diaphragm*

Injuries to the diaphragm may be caused by blunt trauma or by penetrating wounds. Rupture of the diaphragm is a frequent result of blunt abdominal trauma but may also be caused by compressing injuries of the chest. The left side of the diaphragm is more frequently involved than the right. The defect is usually through the dome of the diaphragm, and blunt injury serious enough to cause rupture of the diaphragm is in most patients accompanied by other damage to the thoracic or abdominal viscera. Repair of the rupture of the diaphragm should be carried out as soon as the patient's general condition permits. Penetrating wounds of the diaphragm are important in that there is almost invariable injury to other organs. It is essential to remember that, on deep inspiration, the diaphragm ascends as high as the fourth rib anteriorly and attaches to the eleventh rib posteriorly. Consequently, a penetrating wound fairly high in the chest may also involve the abdominal viscera by going through the diaphragm, and conversely injuries low down in the abdomen may also involve the diaphragm and result in intrapleural problems. If this is borne in mind, such injuries will not be overlooked.

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## TEN-YEAR REVIEW OF BRONCHOGENIC CARCINOMA IN A COMMUNITY HOSPITAL\*

J. JOHN YASHAR, M.D., AND THOMAS MICOLONCHI, M.D.

The Authors. J. John Yashar, M.D., of Providence, Rhode Island, Thoracic Surgeon, the Memorial Hospital, Pawtucket; Miriam, Roger Williams, St. Joseph's and Our Lady of Fatima hospitals, Providence.

Thomas Micolonghi, M.D., of Pawtucket, Rhode Island, Assistant Pathologist, the Memorial Hospital, Pawtucket; Instructor in Pathology, Tufts University School of Medicine, Boston, Massachusetts.

**D**URING a ten-year period from January 1, 1950, to December 31, 1959, a clinical diagnosis of primary lung cancer was entertained in 103 ward and private patients at the Memorial Hospital. In 86 patients the diagnosis was verified by histologic and cytological means, the material being obtained by bronchoscopic biopsy, bronchial washings, biopsy of supraclavicular nodes and metastatic implants, biopsy at the time of thoracotomy, examination of the resected specimen or by postmortem study. Specifically excluded are all cases of metastatic carcinoma and bronchial adenoma. The nature and behavior of the latter group are sufficiently different to warrant exclusion from the group commonly termed bronchogenic carcinoma. Careful follow-up study in 85 out of 86 proven cases were obtained (98%).

### Clinical Data

**YEARLY INCIDENCE.** The number of patients admitted with the diagnosis of lung cancer has gradually increased over the past ten years. During the early part of this study only one to two patients per year were admitted; however, during the past few years ten to sixteen patients were seen annually (Figure 1).

**AGE AND SEX.** Age and sex distribution did not differ significantly from other reported series.<sup>1,2,3</sup> The age of these patients at the time of admission to the hospital ranged from 33 to 82 years (Figure 2). Seventy-three per cent were in the fifth and sixth decades. The male sex was predominant in a ratio of about eight to one.

**SYMPTOMS.** Three patients in the entire

series were asymptomatic. The majority of patients had two or three symptoms. Persistent cough, weight loss, dyspnea, chest pain, and hemoptysis were the chief complaints (Table I). It is to be

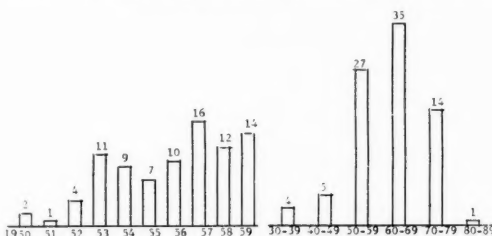


Fig. 1 - Year Distribution

Fig. 2. Age Distribution

emphasized that, although cough was persistent in a high percentage of patients, it was by no means a constant complaint. The high incidence of weight loss and chest pain suggests the advanced state of the disease in many of our patients. Thirteen patients (15%) were diagnosed and treated as unresolved pneumonia for periods of four weeks to four months (average two and one-half months). In eighteen patients (21%) the initial complaint which prompted the patient to seek medical attention was caused by distant metastasis indicating inoperability (Table II).

**DURATION OF SYMPTOMS.** The average duration of symptoms before the diagnosis was established was four and one-half months. Seventy per cent of the patients had symptoms more than three months, 45% more than six months, and 20% more than a year. Three patients

TABLE I  
Symptoms in 86 Proven Cases

Symptoms	No. of Cases
Asymptomatic	3
Cough	47
Weight Loss	32
Dyspnea	26
Hemoptysis	22
Chest Pain	18
Unresolved Pneumonia	13
Pleurisy	4
Pulmonary Osteoarthropathy	2
Others	18

\*Read at the Annual John F. Kenney Clinic Day, at the Memorial Hospital, Pawtucket, Rhode Island, on November 2, 1960.

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**TABLE II**  
Presenting Symptoms Indicating Inoperability

Symptoms	No. of Patients
Headache and Confusion (cerebral metastasis)	2
Backache and Paraplegia	4
Hoarseness	1
Palpable supraclavicular nodes	5
Pain (long bone metastasis)	2
Weakness (widespread metastasis)	4
Total	18

**TABLE III**  
Duration of Symptoms

Duration — Months	No. of Cases
> 1	7
1-3	23
3-6	26
6-9	13
9-12	11
12-18	3
18-24	3

had symptoms for more than two years (Table III).

**BRONCHOSCOPY AND BRONCHIAL WASHINGS.** Bronchoscopy was performed in 56 patients. The findings are listed in Table IV. Definite histologic proof was obtained in 55% of cases. In 15 cases (28%) bronchoscopic study was entirely negative. There has been a high degree of success in obtaining positive cytologic findings in bronchial washings; 75% of bronchial washings were found to be positive. In twenty patients with normal bronchoscopic findings or with simple edema of the bronchial mucosa, bronchial washings were positive in nine cases (45%) (Table V).

**SCALENE NODE BIOPSY.** Since the orig-

**TABLE IV**  
Bronchoscopy Findings

Normal	15
Edema of Mucosa	5
Tumor	20
Distortion and Fixation	4
Narrowing	12
Total	56

**TABLE V**  
Bronchial Washings

Bronchoscopy Findings	No. of Cases	Positive
Total Cases	56	42
Normal or edema of mucosa	20	9
Tumor, distortion and narrowing	36	33

inal reports of Daniel<sup>4</sup> on scalene node biopsy and of Harken<sup>5</sup> on mediastinal node biopsy, a considerable amount of interest has been manifested in the application of these techniques in the preoperative evaluation of lung malignancy. Scalene node biopsy was performed in twenty-seven cases, and positive biopsy was obtained in ten instances (37%). In five patients large supraclavicular nodes were palpable on physical examination, and these were in every instance positive on histological study. Of the remaining twenty-two cases with no palpable nodes, five patients (22%) showed lymphnode invasion by neoplastic tissue (Table VI).

**TABLE VI**  
Scalene Node Biopsy (27 Cases)

Physical Findings	Number of Cases	Positive	Per Cent
All Cases	27	10	37%
Palpable			
Lymph Nodes	5	5	100%
No Nodes Palpable	22	5	20%

**LOCATION.** The right lung was involved by tumor in 48 patients (56%), and the left in 38 (44%). The upper lobes were the predominant site of the disease (47 cases or 56%) and were involved with about equal frequency. The distribution is shown in Table VII.

**TABLE VII**  
Location (86 Cases)

Bronchus	Number
<i>Right</i>	
Upper Lobe	23
Middle Lobe	5
Lower Lobe	18
Main Stem Bronchi	2
Total	48
<i>Left</i>	
Upper Lobe	24
Lower Lobe	9
Main Stem Bronchi	5
Total	38

### Pathology

A simple classification of carcinoma of the lung which has been widely accepted among surgical pathologists is used at the Pawtucket Memorial Hospital:

- Epidermoid carcinoma
- Undifferentiated carcinoma
- Adenocarcinoma
- Alveolar-cell (or bronchiolar) carcinoma

A neoplasm is classified in the epidermoid carcinoma group only if it shows some evidence, though minimal, of keratin or prickle cell formation. All

*continued on next page*

degrees of differentiation may be encountered, even in different areas of the same tumor.

The undifferentiated carcinoma group includes a number of different growth patterns designated as oat-cell type, large-cell type and giant-cell type. One case of undifferentiated giant-cell carcinoma is included in our series. This tumor was composed chiefly of pleomorphic multinucleated giant cells and while in some areas the pattern of cell growth imitated a sarcomatous neoplasm, in others it clearly suggested an epithelial origin. Nash and Stout have reported 5 cases of this neoplasm,<sup>15</sup> emphasizing the extremely grave prognosis and pointing out that the duration of symptoms and average survival rate were shorter than for any of the other histological variants of lung cancer.

Adenocarcinoma must be carefully differentiated from alveolar-cell carcinoma and metastatic adenocarcinoma. This at times may be difficult. The distribution of the histopathological types of tumor in our series is seen in Table VIII. Thirty-four patients had epidermoid carcinoma (43%). Undifferentiated and "oat-cell" carcinoma made up 30% of the group. There was one case of carcinoma *in situ*: in this case the bronchial washings were positive, but histologically the lesion showed only *in situ* malignancy. The proportion of epidermoid carcinoma, undifferentiated carcinoma and adenocarcinoma is in close agreement with that recorded in the literature.

TABLE VIII  
Histologic Diagnosis (78 Cases)

Type	Number
Epidermoid Carcinoma	34
Undifferentiated Carcinoma (Oat-cell carcinoma 5) (Giant-cell carcinoma 1)	28
Adenocarcinoma	12
Alveolar cell (bronchiolar) carcinoma	3
Carcinoma <i>in situ</i>	1
Total	78

#### Treatment and Results

For better analysis of the results for the entire series the patients were divided in four groups:

I. *Far Advanced and Terminal.* These patients were in the terminal stage of the disease, being cachectic and having extensive carcinoma or generalized metastases. In each of these instances the diagnosis was verified by appropriate biopsy material. There were 25 patients in this group, and none have survived. Eight patients received nitrogen mustard and/or X-ray therapy. The majority were dead within a month; X-ray or nitrogen mustard did not seem to improve the life expectancy of these patients.

II. *Inoperable.* Although there was no evidence of distant metastases in these patients, they were considered inoperable on clinical and bronchoscopic grounds. Recurrent laryngeal nerve involvement, invasion of the mediastinal structures, encroachment by the tumor upon the carina or trachea, supraclavicular and scalene node involvement, pulmonary insufficiency and coexisting severe cardiac or renal disease were considered to be definite evidence of inoperability. There were 31 patients in this group. Ten patients received nitrogen mustard, X-ray therapy, or both. All patients in this group are dead from the disease; 65% of these patients were dead within six months, and only one patient was alive after a year. The average survival time was six months.

III. *Thoracotomy.* In these patients preoperative studies did not show conclusive evidence of inoperability. There were thirteen patients in this group and all underwent exploratory thoracotomy. In every instance it was found that due to local extension, the disease was technically inoperable. In 75% of these patients the primary lesion as measured by X ray or on postmortem study was larger than 5 cm. in diameter. There was no operative mortality in these patients. Two cases developed atelectasis and one empyema which responded to conservative treatment. Eleven patients received nitrogen mustard, deep X-ray therapy, or both. None of these patients is alive today. The average survival time was eight months. Sixty per cent of these patients were dead in less than six months. One patient survived twenty months after thoracotomy.

IV. *Resectable.* There were seventeen patients in this group who underwent resection by various members of the Thoracic-Surgical Department. The types of operations which were performed are as follows: pneumonectomy 11, radical pneumonectomy 2, and lobectomy 4. There were two operative deaths within a week after resection. One was due to pulmonary insufficiency and the other to a ruptured arteriosclerotic abdominal aneurysm. Pneumonectomy was considered the preferred operative procedure for all cell types except bronchiolar carcinoma. Lobectomy was performed in small peripheral lesions with no obvious gross hilar lymphnode involvement.

TABLE IX  
Pneumonectomy Cases Still Alive

No. of Patients	Survival Time Months	Pathology	Lymph Nodes
1	11	Epidermoid	—
1	10	Adeno.	+
1	34	Epidermoid	+
1	48	Undifferentiated	+

Of the patients who underwent pneumonectomy after 1956, four are alive today with no obvious evidence of recurrence (Table IX). In the remaining seven pneumonectomy patients that survived the operation one patient died four years after thoracotomy from generalized metastases which it was thought had originated from carcinoma of the trachea. The remaining six patients all died from local recurrence or carcinomatosis from three months to five years after surgery. The average survival time was twenty-three months. (Table X). In the lobectomy group none is alive. Three died from three to seventeen months after surgery from recurrence of the disease. The fourth patient had a right lower lobectomy for carcinoma *in situ*, and died twenty-three months after surgery from myocardial infarction (Table XI).

### Discussion

A review of the literature revealed uniformly discouraging results in bronchogenic carcinoma.<sup>1,2,6,7,8</sup> In spite of the small number of cases treated surgically in this hospital the results do not differ much from those in other reported series (Table XII). The majority of our cases were characterized by insidious onset, paucity of symptoms and rapid growth with early metastases especially in the undifferentiated and anaplastic tumors. Twenty-one per cent of the cases were inoperable at the time of their initial complaint. Only seventeen cases (20%) of the entire series were resectable. There was a high incidence (37%) of undifferentiated and anaplastic tumors characterized by their high degree of malignancy, invasive qualities, and poor prognosis. In our cases there was considerable delay in diagnosis and operation,

TABLE XII

Author	No. of Cases	% Explored	% Resected
Yashar	86	35	20
Kirklin	767	48	24
Ochsner	1170	52	33
Burford	1008	60	35
Overholt	733	62	37

especially in the well differentiated and epidermoid carcinoma group. Forty-five per cent of the patients had their symptoms for more than six months with an average duration of 4½ months. Although Husfeldt<sup>9</sup> reported that the incidence of resectability in cases of bronchogenic carcinoma was practically the same in both early and late cases we can assume that the end result and prognosis were not.

The concept of "biological predeterminism" as suggested by MacDonald<sup>10</sup> and supported by Crile,<sup>11</sup> which is the expression of the biological potential established during the preclinical phase of neoplasia, explains the variegated pattern of behavior and prognosis, and establishes the selection of cases on a more logical basis. Blood vessel invasion by tumor which is a frequent occurrence in undifferentiated carcinoma accounts for the poor prognosis in many cases.<sup>13</sup>

It should be remembered that carcinoma of the lung has an insidious onset, yet is 100% fatal if allowed to go unrecognized or if treated by X ray or chemotherapy. None of the symptoms of this disease are pathognomic. Dr. Ochsner<sup>12</sup> once pointed out that presence of symptoms in cases of lung cancer is evidence of extension of tumor and makes the prognosis poor. Unnecessary delay in

*concluded on next page*

TABLE X  
Pneumonectomy Cases Not Alive

No. of Patients	Pathology	Lymph Nodes	Survival Time Months	Cause of Death
1	Undifferentiated	—	60	local recurrence
1	Undifferentiated	+	48	ca. trachea
				carcinomatosis
1	Epidermoid	—	23	carcinomatosis
1	Undifferentiated	+	16	local recurrence
2	Epidermoid	+	7	carcinomatosis
1	Oat Cell	+	3	carcinomatosis

TABLE XI  
Lobectomy Cases Not Alive

No. of Patients	Pathology	Lymph Nodes	Survival Time Months	Cause of Death
1	Carcinoma <i>in situ</i>	—	21	Myocardial infarct
1	Epidermoid	—	17	Local recurrence
1	Epidermoid	+	8	Carcinomatosis
1	Adeno ca.	+	3	Local recurrence

arriving at an accurate diagnosis because of a lack of characteristic clinical manifestations or symptoms may cause the patient to lose his only opportunity for ultimate cure. The admonition of Overholt should be followed that if cancer potential in a given case is more than 1%, exploratory thoracotomy is indicated. The risk of such a procedure in experienced hands is less than 1%.<sup>14</sup> Cancer of the lung may present itself with such variable symptoms as changes in the character of a cough, hemoptysis, weight loss, or unresolved pneumonia. Forty per cent of cases of unresolved pneumonia in older patients prove to be due to bronchogenic carcinoma.<sup>16</sup> Fifteen per cent of our patients had symptoms diagnosed as unresolved pneumonia before a definite diagnosis of carcinoma was established. Bronchoscopy, bronchial washings, and scalene node biopsy are of great help, not only in establishing the diagnosis, but in showing extension of the disease. Once the diagnosis is made, the treatment is based on the concept of biological predeterminism. Selection of the operative procedure depends on the cell type, location, size, and extent of the tumor. Pneumonectomy as a curative procedure is considered the operation of choice for all cell types except bronchiolar carcinoma. Lobectomy may be indicated in a small peripheral lesion with no obvious hilar lymphnode involvement, or as a palliative procedure in those patients with poor pulmonary and cardiac reserve.

### SUMMARY

1. A statistical study and follow-up of 86 proven cases of bronchogenic carcinoma observed between January 1, 1950 to December 31, 1959 is presented.

2. Symptoms, age, sex distribution, bronchoscopic findings, and cell types are discussed.

3. Surgical exploration was carried out in thirty patients (35% of cases). In fifteen patients (20%) resection of the tumor was possible by pneumonectomy or lobectomy.

4. Early pulmonary resection, although leaving much to be desired, provides the best chance of cure in bronchogenic carcinoma.

### Acknowledgment

We are grateful to Miss Lillian Koutras, secretary of the Tumor Clinic, for invaluable assistance in collecting the follow-up data.

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### DOCTOR JOHN E. DONLEY

Although Rhode Island is the smallest state in the union, its medical journal is one of our favorite exchanges. It has consistently maintained a high standard of original articles and of editorial content. Doctor Donley was a worthy successor to the brilliant and lovable Peter Pineo Chase, who died in harness, April 23, 1956. Now Doctor Goldowsky has a large pair of editorial shoes to fill — but no doubt will keep the RHODE ISLAND MEDICAL JOURNAL on the same high level as his predecessors. He does not come as a novice, since for many years he has been an associate editor.

The NORTH CAROLINA MEDICAL JOURNAL extends to the Rhode Island Medical Society sympathy in the loss of Doctor Donley, and congratulations on having a capable successor in Doctor Goldowsky.

... Reprinted from the editorial pages of the  
NORTH CAROLINA MEDICAL JOURNAL,  
November, 1960.

### 150th ANNUAL MEETING

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*Masters in Medicine . . .*

## LEONARDO AND VESALIUS

## The Two Roads: Surgery and Science \*

FRANCIS D. MOORE, M.D.

Moseley Professor of Surgery, Harvard Medical School; Surgeon-in-Chief, Peter Bent Brigham Hospital

Dr. Moore talks softly and carries a big moral at the conclusion of this historical and artistic essay. We liked it, even without the moral. This shortened version is taken from the book, *Disease and the Advancement of Basic Science*, edited by Dr. Henry K. Beecher, published last summer by the Harvard University Press.

ALTHOUGH we live in a period when it is appropriate to foster fundamental science and somewhat old-fashioned to defend applied science, I should like to emphasize that very important and elegant work of applied human biology, the study and practice of medicine. It is my contention that the general atmosphere surrounding the care of the sick has always been one of the chief factors in the advancement of biological science. This atmosphere is one of urgency, a stronger motivation than any other community drive except national defense, a promise of possible help in the relief of suffering. The careers of two men of the Renaissance test, if not prove, my contention that the care of the sick has provided a most fertile milieu for the advancement of science. These two men are Leonardo da Vinci and Andreas Vesalius.

It has been said many times that Vesalius was the man who opened biological science as we know it now, by first looking at the human body just as an astronomer might look at a star or a botanist might inspect a tropical plant. He studied and drew human anatomy in a way that was entirely original and was most significant for the growth of biological science. Vesalius lived from 1514 to 1564 and he did his major work in Padua between 1535 and 1545.

It is therefore especially interesting to consider that the pictures by Leonardo shown on these pages were made fifty years before those of Vesalius. They are elegant anatomy, superb science, and surpassing art and yet they had no influence whatsoever on the growth of anatomy.

There is a striking contrast between the scientific impact of these two men, who worked in the same field within 100 miles and within fifty years of each other. Leonardo was born in 1452. He died in 1519, when Vesalius was five years old. Leonardo's early period of anatomical interest was

between 1487 and 1490, during which time he became interested in anatomy and dissected a few arms and legs, and, due to local practice, heads; but he did not have much opportunity to carry out dissection of an entire cadaver until about 1510 in Florence.

In view of the remarkable importance of Vesalius, it is especially interesting now to look back at Leonardo and try to understand why he had no influence whatsoever on biological science or anatomy when much of his anatomical observation was just as accurate and penetrating as that of Vesalius and his scientific interest just as "pure."

It is a common misconception that Leonardo's anatomical study was undertaken so that he could become a better artist. Leonardo's anatomical study was approached with exactly the same thoroughness and enthusiasm with which he approached the many other things in which he was interested, including engineering, aviation, military science, and architecture. He went into the matter of the structure of man with his full inquiring vigor and went far deeper into anatomy than was necessary merely to draw the surface. He also developed ideas for anatomical study, dissection, and teaching — ideas which were entirely original with him and were actually quite lost, even to Vesalius, and not rediscovered for several hundred years. These were most especially the technique of the sagittal section, the coronal section, the cross-sectional anatomy, and the concept of depicting an anatomical part as it looked from many aspects rather than just as seen from the front. If one looks through the newly republished collections of Leonardo's anatomical studies, one finds in them in essence all of the qualities which gave Vesalius such a key position about fifty years later. Yet, as nearly as we know, Leonardo had little influence on anatomical or biological science. His influence on art, architecture and engineering were extensive, so that we cannot assign to Leonardo any inability to communicate.

Both Leonardo and Vesalius were eminent men in their own times, very vocal, very egotistical; they taught widely, both of them loved to write and to draw pictures. We can accuse neither of them

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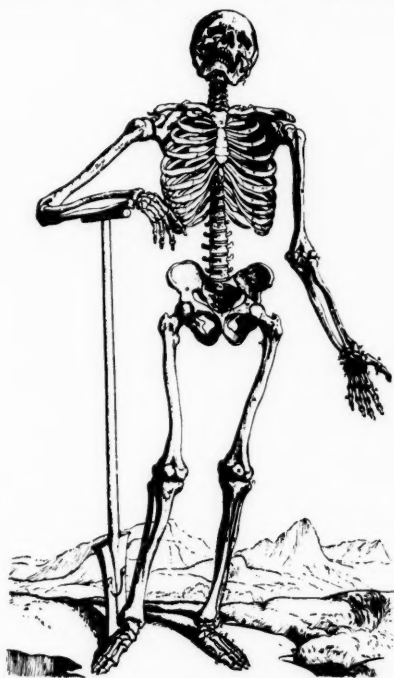
of having the slightest desire to hide his light under a bushel. But the fact of the matter is that Leonardo, who was isolated entirely from the environment of the care of the sick, had virtually no influence on the growth of biological science. He was not surrounded by others interested in becoming his pupils in anatomy or in seeking the application of anatomy to the care of the sick.

Vesalius, by contrast, worked with the sick and taught at a medical school. He was a professor of surgery and he was made professor at Padua at the age of 23. Vesalius' anatomical science was every bit as "pure" as the most abstract study of physics or chemistry might be today. There was no clinical application whatsoever for proper understanding of anatomical relations. Vesalius sought the truth as he could see it in terms of anatomy. But he was in a medical school, he was looking after the sick at the time, and he was surrounded by students. His influence was immediate, explosive, far-reaching, and indubitable. His chair at Padua saw successively Fabricius, Fallopius, and William Harvey. His work was plagiarized all over Europe, even before he died, and within one hundred years of his death academic dogmatism had run full circle, accusing him or copying him, usually a sign of success.

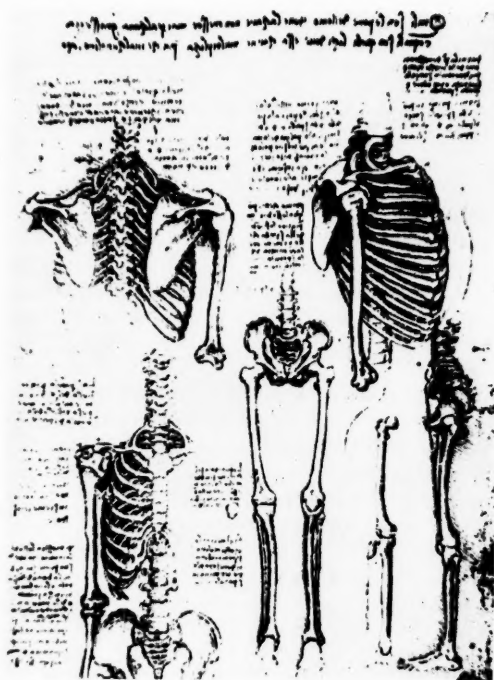
Jacob Bronowski, the author of *Science and Human Values*, points out that the two great periods of scientific birth, in Greece and in the Renaissance, were periods when science and art existed side by side, both of them in a very florid form, and that it was more than a coincidence that within twelve years in England were published the Authorized Version of the Bible, the First Folio of Shakespeare, and the first table of logarithms. Bronowski is also interested in the sort of individual who becomes creative in science. He says "a man becomes creative, whether he is an artist or a scientist, when he finds new unity in the variety of nature. He does so by finding a likeness between things which were not thought alike before and this gives him a sense both of richness and of understanding."

There certainly have been very few physicians or surgeons who could answer this description, especially when we think that in Bronowski's lexicon there are only about thirty men since 1450 who would be considered as fulfilling this definition. Both Leonardo and Vesalius qualify.

We thus find that within fifty years there were two men working close together in the same country and with the same kind of material, opening up observational science and biology by depicting accurately the structures of the human body as based on actual dissection. One of them, whose work was in association with the care of the sick and with students of medicine, had a tremendous



The skeleton: Leonardo (below), Vesalius (above). Leonardo avoids the dramatic poses used by Kalckar and Vesalius, and also by DaCarpi who may have set the style.







The superficial muscles: Leonardo (above), Vesalius (below). Leonardo's figure has a sturdy stance and sense of weight-bearing. The Vesalius, again, is a dramatic pose against the famous landscape background that was later identified outside Padua.



influence on the growth of science, and the other, who was isolated from this environment, did not. This duality epitomizes a main contribution of the care of the sick to the growth of biological science which has become the largest, most heavily populated and heavily communicated branch of all science and the one wherein advance can most readily find expression in terms of human welfare, undeniably an objective of even the most abstract scientist.

The two roads, surgery and science, have surely not always been together but in 1543 they were in one man. Despite this glorious conjunction, however, the two roads of surgery and science wandered quite separately for about 300 years, as biological science developed successively the fields of chemistry, physiology, pathology, biochemistry, metabolism, and biophysics, and surgery floundered in a morass of empiricism. The two roads converged again in 1850, and formed a union to which all of the advance in surgery in the last fifty years may be traced. The problem today is that of maintaining this unity and this growth. It is my conviction that this can best be accomplished by fostering the support of individuals who combine both talents in one career.

There are several serious problems which, if unsolved, are going to arrest the spectacular development of American surgery. These problems have to do with the career arrangements of those men who are talented in both fields. The practice of medicine or surgery is a time-consuming profession. The young surgeon who is forced to support himself cannot hope to find the time necessary to remain productive in clinical investigation. As he grows older he has an increasing tendency to retire from the attempt and to employ other individuals, now referred to as "basic scientists." Maybe this works somewhere, somehow, but I think in general it is an unfortunate trend. If this practice becomes widespread, the present healthy growth of surgical science is going to slow down and stop. That growth has been due to the willingness of single individuals to take the gamble and the sacrifice of a double career in science and surgery. But we should not require of these men too expensive a sacrifice.

The idea of leaving the young clinical investigator alone to do his work and giving him adequate support has been lost sight of completely. The so-called "pure" scientist can find support from many sources and is often paradoxically free of academic interruption, especially if he works in a hospital. It is the young man who wants to follow both roads together, clinical study and laboratory science, who must be freed and supported. It is because of him, not because of the career laboratory scientist, that we must go back to the simple concept of the full-time system, now essentially abandoned, for the

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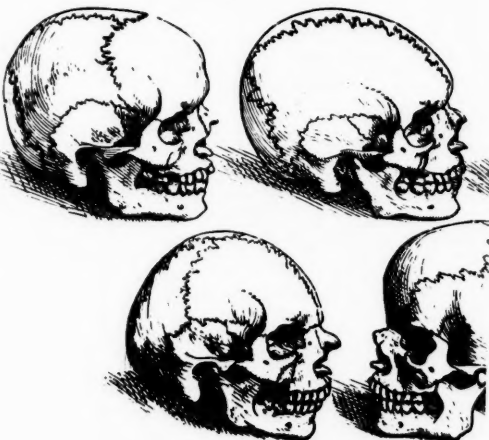
support of the talented young surgeon.

The disturbing fact that we are drifting by small degrees away from the full-time system, so elaborately constructed about fifty years ago, is largely due to shrinking university endowments and sorely pressed hospital funds which will not permit the most important people in the younger age group to enjoy the freedom of full-time devotion to clinical investigation. A man in the first ten years out of his residency, with a wife and from two to six children, has to have support if he is to be free to study. Most departments have tried to seek out a solution through national grants, but even these, with few exceptions, are very limited as a source of continuing personal support. As a result, many young doctors find it to their economic advantage either to do nothing but research, in which case they retire to the laboratory, or to pursue entirely clinical practice, in which case they do well financially but their value to the advance of surgery is lost.

The need to follow the two roads at once not only applies to the individual but also to the balance within the hospital staff. While the laboratory is at the heart of the advance of modern medicine, under no circumstance should it be permitted to take control. The teaching hospital, to be a place of good investigation in the hundred years to come, must seek first and foremost to maintain its status as a place for the good care of the patient.

Our task today is to foster the careers of people who are talented and willing to contribute by keeping surgery and science close together. For this to be possible we have to go back to the fundamentals of modern academic life and re-explore the meaning of the full-time system. Hospitals and medical schools have thus a remarkable opportunity and also a responsibility in seeing to it that young men of great talent are not distracted by the need for practice during the years in which they can make the greatest contributions both to science and to surgery. It is they who will keep the two roads well paved and well traveled in the future years.

The skull: Leonardo (below), and Vesalius (above). Leonardo uses both coronal and sagittal sections. His rendering of the cervical vertebrae is stylized, probably because his specimen had been decapitated.



## E. P. ANTHONY, Inc.

### *Druggists*

WILBUR E. JOHNSON, Phar. D.  
RAYMOND E. JOHNSTON, B.S.

178 ANGELL STREET  
PROVIDENCE, R. I.

GA Spee 1-2512  
Pharmacy License #225

150th ANNUAL MEETING

MAY 2 and 3, 1961

RHODE ISLAND MEDICAL SOCIETY

## CHEMICAL AND GENERIC vs. TRADE NAMES

**I**S THE STATE wasting money because its doctors prescribe drugs by brand names, rather than generic or chemical names?

The press has recently spotlighted the problem with a headline: *Rhode Island looks into drug costs for welfare cases*. "The state," so runs the feature article, "is seeking advice from the Federal Food and Drug Administration as to whether or not it should ask doctors to prescribe some drugs for relief patients by generic name or chemical name, instead of the usually much more expensive brand name."

The decision to seek advice from the FDA came about through the efforts of Rhode Island health committees meeting to discuss their mutual problems. Committees of the Rhode Island Medical Society, the Rhode Island Pharmaceutical Association, and an Advisory Committee of the State Welfare Department exist to bring to the people of Rhode Island the best possible health care for the lowest possible cost. For instance, in September 1959, the State Welfare Department, after several meetings with these groups, issued an informative directive to the physicians and druggists in the state establishing policy for antibiotics, vitamins, hormones, tranquilizers and appetite depressant drugs.

In October, 1960, the State Welfare Department met with the Advisory Committee on Social Welfare of the Rhode Island Medical Society. The Welfare Department presented for consideration a list of ten drugs with prices varying among a number of companies. The addresses of the companies offering lower prices were unknown to either the Welfare group or to the Advisory Committee. Because of the lack of basic knowledge of the companies involved, the welfare group was instructed to write to the FDA Commissioner in Washington to seek guidance. Specific information was sought concerning production and marketing facilities of each of the companies quoted as to whether or not the drugs listed met FDA standards, and especially

as to whether the quality, potency, and therapeutic efficacy was as claimed. It was this incident which caught the interest of the press.

The problem is also of top interest to the physicians and druggists of Rhode Island. It is not as simple as the Kefauver report would have the laity believe. Some homework needs to be done on the situation. Anonymity of drugs holds great dangers for the American people.

Most drugs used in medicine have three names. First is the chemical name, usually very complicated, hard to understand by anyone but chemists. Because of this difficulty, the use of generic names was introduced, often derived from the chemical name, but easier to remember, pronounce, and write. Finally, there is the trade-mark name designating one particular manufacturer's exclusive brand of the drug in question.

Many drugs are now being offered to physicians by mail by unfamiliar companies, at lower prices than are asked for such drugs when they are made by ethical manufacturers and sold through prescription pharmacies. These cheap products have no brand insigne on them, a guarantee that the manufacturer is willing to acknowledge his product, to stand behind it, and to be responsible for its claims.

Drugs are a physician's tools. They should be of the best materials, but not necessarily of the cheapest. The physician has to depend on the integrity of the drug manufacturer to assure that his drug is of high quality and that it is of the same quality which has given satisfaction in the past. Few physicians are willing to prescribe drugs simply because they are cheap; they believe that welfare patients should have medical care equal in quality to that received by other patients. If they are sure that a non-brand name drug can meet the test of quality and efficacy, they would have no hesitation in prescribing it.

But how is the physician, without the necessary time or facilities, to investigate claims that so-

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called generic equivalents are really equivalent. His experience has shown him that such preparations are often short-dated and sometimes out-dated. He needs to know if the drug manufacturer is reliable. Does he insist on drug quality and exactness of ingredients? How does the therapeutic efficacy of the drug which he sells compare with that of the ethical manufacturer from whom he has copied it and who has perhaps spent millions of dollars in its research and development?

In a recent survey, two products of an unfamiliar company were bought on prescription by generic name from various pharmacies in several cities. When analyzed, the active ingredient content of these so-called generic equivalents fell outside U.S.P. limits in 35% of the cases, while a similar quantity of branded drugs bought at the same time yielded in all cases precisely the amount of the active ingredient which was listed on the label. This is no isolated case. One antibiotic was found to be 50% more effective than a supposed equivalent with a different filler. The therapeutic value of a drug depends upon how much of it is absorbed and how rapidly or slowly, giving great importance to such factors as tablet coating and filler. Variations can be extreme among drugs; and, as the drug becomes more complex, possibilities for differences multiply.

Allowing the substitution of less costly "equivalents" or "generics" for specific brand-name drugs prescribed by a physician for a welfare patient shifts the responsibility for the well-being of the patient from the doctor to the druggist. This practice is dangerous for the patient; it is questionable legally. Druggists do not condone it, and it is not good for the doctor who must hold himself rigidly to his ethical standards.

No physician should be required, as is sometimes the custom, to provide a statement certifying

the need for a drug. If it were not necessary, he would not have prescribed it. The one best qualified to make this decision is the attending physician. Should a physician misuse this prerogative, there is the regular machinery for handling such complaints within the profession: the Grievance Committee of the Rhode Island Medical Society. It is hardly necessary to introduce a dangerous and questionable custom which is very likely to boomerang.

What about cash savings? The Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings to the department of "generic" versus "trade-name" drugs. The drugs had cost \$28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5% (\$1,400). Syracuse has made a similar study in drug costs with comparable results. Even though a small saving might accrue to the state if the prescribing of drugs by their generic names should become established, in the final analysis a drug program should not be designed solely to induce economy. It must also assure that quality medical care is being given.

Continued co-operation of the Advisory Committees of the Rhode Island Medical Society with the State Welfare Department is desirable to promote discussion of welfare medical care programs, and to find solutions for the drug and other problems. Periodic evaluation of the drug program from a medical, administrative, and financial point of view should be carried out. An educational program is desirable, directed to personnel of the state and local welfare offices and to recipients, for the purpose of distributing complete and accurate information about the health care program, and of obtaining co-operation in eliminating abuses as well as extravagant and unnecessary practices.

## THE PHYSICIAN'S RESPONSIBILITY TO THE HARD OF HEARING

WHEN A PERSON becomes hard of hearing he needs firm guidance by his doctor; he is otherwise bewildered and tends to take advice from various friends who have conflicting ideas.

*First and foremost he should see an otologist.* The condition may be helped by treatment. If this is not possible the otologist is the one to advise him as to what he should do.

If a hearing aid is advised, he should get one promptly. The otologist should advise him where to go and what kind of aids to try. The best hearing aid is the one that helps the hearing most. Extra expense for making the aid inconspicuous is usually wasteful, and sometimes makes the aid less efficient.

Most people find the hearing aid helpful, but some are not sufficiently helped to allow them to function efficiently and comfortably. These people should take lip reading lessons. It is extraordinary the benefit one can get from a hearing aid and lip reading study combined.

All this advice, tailored to meet the individual need, is given by the otologist. Hearing aids can be bought from the hearing aid dealers. Lip reading teachers are available. Those who want further help in the details of hearing aid evaluation and lip reading study should visit the Providence League for the Hard of Hearing.

Some hospitals are developing hearing centers

where highly expert examinations and advice are available. The state department of Social Welfare is financing the care of those getting state aid.

However, the guidance of the hard of hearing people is still the responsibility of the medical profession.

## THE CHARLES V. CHAPIN HOSPITAL

THIS HOSPITAL, where the epoch-making studies of Doctor Chapin were put to practical use in the care of contagious disease and the value of medical asepsis was clearly demonstrated, continues to be a most valuable institution despite the fact that modern medical advance, particularly the use of antibiotics and chemotherapy, has greatly reduced the number of patients with bacterial disease who are sent to it. Poliomyelitis, encephalitis and other conditions of virus, rickettsial or other origin still need the expert diagnosis and treatment that has been characteristic of the work in this hospital, and we must still admit that bacterial infections are by no means entirely defeated.

Doctor Dennett L. Richardson, its first superintendent, not only put the ideas of Doctor Chapin to practical use and developed techniques that were models for contagious disease hospitals everywhere, but also, by precept and especially by exam-

ple, trained a group of experts whose work, meticulously carried out in every detail, was of the highest type. Among these, the famous team of Gregory, West and Bell could probably not be exceeded in downright skill and efficiency anywhere in the country. Harmon B. P. Jordan, Raymond E. Stevens, and many other well-known physicians were also among those who trained at this hospital, and went on to other fields. A member of this group, Doctor Hilary Connor, is particularly to be congratulated at this time, as he retires from his post as superintendent in which, in carrying on the work so ably begun by Doctor Richardson, he has made an excellent record. And in offering its felicitations to him the JOURNAL also extends them to his successor, Doctor Edward J. West, a member of the triumvirate mentioned above. We are proud of the record of this hospital and happy that its future is in such capable hands.

## STRAWS IN THE WIND

SEVERAL RECENT court opinions appear to give reason to hope that the tide of malpractice suits may have begun to ebb. In a recent decision a California court sharply limited the extent to which laymen will be permitted to judge strictly medical testimony. The court in this case refused to permit a jury to judge a suit based entirely on X-ray findings. Claiming that the doctrine of *Res Ipsa Loquitur* must be applied, the plaintiff's attorneys argued that X rays of a fractured leg indicated such gross negligence in the setting of a fracture, that expert testimony would not be necessary. The court ruled that a layman, depending on common knowledge and without expert testimony, was not qualified to judge the result, however unfortunate it might be. It dismissed the case for lack of expert testimony and was affirmed by the District Court of Appeals. Coming as it does from the home grounds of *Res Ipsa Loquitur* this is an encouraging development indeed.

Other developments are significant. The New York State Supreme Court has now ruled that "the weight of medical authority does not necessarily depend upon the number of doctors who agree to a certain method." This ruling was handed down in a suit against the State of New York in-

volving a patient who was permanently paralyzed following an intraspinal injection of tetanus antitoxin given in accordance with directions issued by the Department of Health. The Court ruled that the result "must be attributed to the misfortunes of life" and that "there is no authority that a doctor . . . must use what some doctors consider the best method if a method which is accepted by respectable medical authority is adopted." This represents further progress in New York State where the climate has already been greatly improved by the utilization of impartial medical testimony under the jurisdiction of the court.

There is good evidence that the trend of malpractice litigation in California which was straight up from 1945 until 1957, leveled off in that year, and that in 1959 there was actually a slight falling-off in both suits and claims. It was felt that in the most litigation minded of states this was due to the educational efforts of the California Medical Society in informing the public that poor results do not of necessity imply negligence, and in setting up machinery to evaluate complaints. This latter device has long been in operation in Rhode Island.

These are indeed encouraging signs, and we certainly hope that they are straws in the wind.



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## THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS\*

ALEX M. BURGESS, SR., M.D., F.A.C.P.

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*The Author. Alex M. Burgess, Sr., M.D., F.A.C.P., of Providence, Rhode Island. Member of the Joint Commission on Accreditation of Hospitals, 1952 — .*

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IT IS A PRIVILEGE to discuss the subject of our Joint Commission on Accreditation of Hospitals. I say *our* advisedly, yours and mine, for your American Hospital Association and the American College of Physicians of which I am a fellow are two of the four constituent members of the Corporation of this organization. You remember, I am sure, that for years, beginning in 1919, the American College of Surgeons alone and on its own initiative carried on the much needed function of examining and accrediting hospitals, which was formally turned over to the Joint Commission in December, 1952. Three of the present commissioners, Doctor Julian P. Price and Doctor Stanley R. Truman and I have served on the Commission since that date. The first executive director was Doctor Edwin L. Crosby, now executive director of the American Hospital Association and the second and present incumbent is Doctor Kenneth B. Babcock. As I am sure you know, both of these men have had years of experience as hospital administrators and, I may add, it would be difficult if not impossible to find two individuals better qualified to fill this important position.

Besides the two members of the corporation which I have mentioned there are, as you know two more, the American Medical Association and the American College of Surgeons. The policies of the Commission are determined by a Board of Commissioners of which the American Hospital Association and the American Medical Association furnish seven each, and the College of Surgeons and the College of Physicians three each. The funds to carry on the work of the commission including the salaries of the group of physicians who conduct the actual surveys of hospitals are furnished by the four constituent member organizations in proportion to their representation on the Commission. In the case of the American Medical Association and College of Physicians, the

surveyors which they support give their full time to the work of the Commission while those employed by the American Hospital Association and College of Surgeons combine their surveys for the commission with other duties and, therefore, there have to be more of them to make the division of the support by the members of the commission an equitable one.

With this background information you are doubtless familiar and also with the fact that the Joint Commission is a voluntary organization which, on receiving a written invitation, will survey any hospital listed as such by the American Hospital Association without cost, if it has at least twenty-five adult beds and has been in operation for at least twelve months. The reports of the surveyors are received by the director who has the power to alter the recommendation of the surveyor if he sees fit to do so. A report of all surveys made each month goes to every commissioner with a detailed statement of the reasons for anything less than full three-year accreditation in the case of every hospital which receives such a low rating. As you are aware, accreditation for one year only constitutes a warning that all in a hospital is not well, but does not take away the accreditation, which can be again awarded on a three-year basis if a subsequent survey shows that deficiencies have been corrected.

The Standards for Accreditation, adopted by the Board of Commissioners, are embodied in a document which has been revised and, we hope, improved, from time to time. They "have evolved from years of experience in observation of those hospital practices which have proved consistent with high quality *patient care*." (From the introduction to the New Standards which have just been adopted.) Patient care is the watchword, and it is with patient care and nothing else that the Joint Commission is concerned. Many things, the physical plant, the organization of the staff and the activities of committees for example, all have a direct bearing on patient care. Although educational programs and research in a hospital are also in the broad sense related to the care of patients, these are functions with which the Joint Commission does not deal.

\*A report given at a meeting of the American College of Hospital Administrators, at Philadelphia, Pennsylvania, October 13, 1960.

The new standards, of which you will receive a copy, consist of a one-page statement of *Basic Principles* and then *Standards of Procedure* which in its typewritten form occupies twelve pages. The staff of the Commission will prepare for the commissioners a detailed statement of all changes that have been made in the previous standards, but this is not yet available and this you yourselves can easily do, if you so desire, when you receive your copies, as you will in the very near future. The new document is the result of the work of the Committee on Standards which has labored long and hard, weighing every word and phrase and carefully discussing the possible variations in interpretation that may be made. It has subsequently been checked by the whole commission with but few minor alterations resulting, and then adopted.

With the new Standards you will also receive what is, we believe, another and important document prepared by Doctor Babcock and his excellent staff. Although this has, as yet, been given no title it is in fact an elaboration, explanation and interpretation of the standards and should prove to be of great value. It is quite impossible for even the legal profession to prepare statements that cannot be interpreted in more than one way. In the case of these new standards, these explanatory statements make clear, as far as is humanly possible, what the Board means by what it says in the Standards. They also elaborate on the simple statements of the Standards and make clear how they should be applied. All the Commissioners have studied this document and have suggested a few minor alterations. It has then been officially adopted.

Examples may interest you. In the standards it is noted that "the hospital shall provide . . . a sanitary environment to avoid sources and transmission of infections." The new document devotes three pages to methods suggested to accomplish this. These are suggestions, not requirements, but certainly measures such as those described are necessary to accomplish the objective. The establishment of a staff committee on infections, for example, is recommended, an action which has been previously suggested by the commission and has been pretty generally adopted by good hospitals, as would certainly have been the case whether or not the Commission had recommended it. This leads me to say that most of the standards of procedure and excellent ways to carry them out would be adopted anyway by almost all good hospitals, but protection of the public demands that definite requirements be stated so that the rather rare hospital whose authorities would not otherwise keep its practices up to standard will be forced, if it wishes to maintain its accreditation, to mend its ways. It would be a good thing too, as I think we

would all agree, if it were possible in a similar way to coerce the small minority of physicians whose work is substandard into mending their ways. Though this can and should be done in hospitals, one cannot easily imagine how it could be accomplished in private practice in offices and patient's homes.

### *Control of Quality of Patient Care*

This leads directly to a consideration of control of the quality of patient care in the hospitals. This has been carefully considered by the Commission. Two methods, the Medical Care Appraisal Plan of the American College of Physicians<sup>1</sup> and the Medical Audit Program of the Commission on Professional and Hospital Activities have been discussed, but the Joint Commission is not willing to indicate that any specific method should be adopted. It will recommend that hospitals employ some procedure such as these that I have mentioned, to accomplish the objective.

This is in line with the thinking of the Commission. Although it has been accused of great rigidity in its insistence on its requirements, this is, I believe, not true and is chiefly the result of the necessity to give the surveyors definite checks to be made in all appropriate phases of hospital work that bear on patient care. Actually the Commission is interested in the objectives to be attained and not in the exact method by which this is accomplished. Whatever results in high quality care of patients is good and the exact details of the method by which this is brought about are not important. For example, in one hospital with which I am acquainted the quality of patient care on the medical service is determined by constant surveillance by the Chief of the service who, at a definite risk to his popularity and with a great expenditure of time and effort, personally checks the records of service and private patients and makes it his business to know how these patients are being treated. He is an efficient committee of one and he does the job.

It may occur to you that the percentage of autopsies performed in a hospital is primarily related to education rather than to the care of patients. While this is perhaps true, the Joint Commission takes the attitude that the review of clinical work and the experience thus gained at the autopsy table constitute an important part of the "Analysis, Review and Evaluation of Clinical Practice" which is a must in the continuance of good treatment of patients. "Autopsies, as a means of staff education and improvement of clinical knowledge rank extremely high in the minds of the Commissioners." They believe that non-teaching hospitals should have at least a 20 per cent autopsy rate and teach-

<sup>1</sup>Annals of Internal Medicine 517:821 October 1959  
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ing hospitals at least a 25 per cent rate." (This is, I believe, very low.) I would like to mention also that the Council on Medical Education and hospitals of the American Medical Association and its Internship and Residency Review Committees do demand a considerably higher autopsy percentage than does the Joint Commission. Incidentally, I may add, there should be no such thing as a "non-teaching" hospital. What is meant here is a non-university-affiliated hospital. I believe we will all agree that all hospitals should be "teaching" in the strict sense and all should have educational programs of greater or less magnitude to suit their needs.

The Commission has been roundly and at times rightly criticized for some of its requirements and has always given such criticisms careful attention. The requirement for consultations, for example, as originally received from the College of Surgeons, was bitterly criticized, then carefully revised and now appears to be satisfactory to all concerned. The same is true of the requirement of attendance at staff meetings, the determination of which has been returned to the hospitals to be incorporated in their bylaws.

A comparison of the newly adopted "Standards" with those dated October 1, 1957 shows a few important changes and many instances of rewording to improve the clarity, simplicity and clear arrangement of the text. One of the most important of the changes from the point of view of hospital staffs is the deletion of all requirements of attendance at staff meetings as has been mentioned. Responsibility for adequate meetings, minutes and staff attendance has been placed in the hands of the individual hospitals. "Attendance requirements for all medical staff meetings shall

be determined by the active staff." This is quoted directly from the new standards. The different methods of fulfilling the requirement that adequate meetings shall be held have been rewritten and clarified, and certainly do not ask any hospital staff to do more than it normally would in carrying out its responsibilities. It is to be noted, however, that adequate minutes of all meetings are required. This is the phase in which many hospitals are deficient, but, I think we all agree, should be meticulously done, for in this matter as in all types of medical and scientific work the old saying is still true "Observations unrecorded are lost."

### *Review of Monthly Reports*

You may be interested in the type of monthly report received by every member of the Board of Commissioners. I shall show parts of a typical report. These each commissioner goes over with care and then, if he approves, he signs an approval slip and mails it back to Doctor Babcock's office. When all approvals have reached the office the action of the commission becomes official.

As you have all received many communications from the Commission, I am sure that a detailed explanation is not needed. You know, for example, that besides pointing out major deficiencies that may cause a change in the status of a hospital's accreditation, it is the rule that minor deficiencies which the surveyor observes and suggestions for improvement are sent to every hospital surveyed. It would, I suppose, be impossible for a hospital, with all the details of its equipment and operation, and the many activities of its staff, to be so perfect that a keen surveyor could find nothing which could be made any better. The suggestions that result from the surveys, like the surveys them-

### JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

200 East Ohio Street, Chicago 11, Illinois

#### *Summary of Recommendations for Accreditation*

May 1, 1960 — May 31, 1960

	Total	Three-Year Accreditation	One-Year Accreditation	No Accreditation
Total .....	152	119	29	4
Initial Survey .....	4	.....	2	2
No Change in Status .....	107	101	6	.....
Upward .....	22	18	4	.....
Downward .....	19	.....	17	2
UPWARD			DOWNWARD	
One year to three year .....	16		Three year to one year	17
NA to three year .....	2		Three year to NA .....	1
NA to one year .....	4		One year to NA .....	1

FIGURE 1

This is a general summary of one month's work showing the over-all results of the surveys.

Surveyor: \_\_\_\_\_, M.D.

Member Organization: J.C.A.H.

	<i>Beds</i>	<i>Previous Survey</i>		<i>Present Survey Recommendations</i>		
		<i>Date</i>	<i>Result</i>	<i>Date</i>	<i>Surveyor</i>	<i>Final</i>
4	80	'57	3 yr.	7-28-60	3 yr.	3 yr.
	214	'57	3 yr.	7-29-60	1 yr.	1 yr.
	329	'57	3 yr.	8- 1-60	3 yr.	3 yr.
	460	'57	3 yr.	8- 2-60	3 yr.	3 yr.
	380	'57	3 yr.	8- 4-60	3 yr.	3 yr.
3	102	'58	3 yr.	8- 8-60	3 yr.	3 yr.
	417	'59	1 yr.	8- 9-60	1 yr.	NA
1	52	'55	NA	8-11-60	NA	NA
2	34		Init.	8-12-60	NA	NA
	51	'59	1 yr.	8-17-60	3 yr.	3 yr.
	109	'57	3 yr.	8-18-60	3 yr.	3 yr.
	145	'57	3 yr.	8-19-60	3 yr.	3 yr.

1. \_\_\_\_\_ Hospital — NA

Little staff organization.

Clinical review not recorded.

Incomplete medical records.

Obstetrics not segregated.

2. \_\_\_\_\_ Community Hospital — NA

Little staff organization.

Poor medical records.

Low autopsy rate.

3. \_\_\_\_\_ Hospital — NA

Overcrowding.

Understaffed.

Psychiatric hospital apparently for domiciliary care.

4. \_\_\_\_\_ Hospital — 1 year

No clinical review for past seven months.

Old portion of physical plant inadequate.

FIGURE 2

The results of the monthly surveys by one surveyor. The reasons for the less than three-year approval for four hospitals are noted in lower half of figure.

selves, are of course intended to help hospitals improve the care of their patients. It is understandable, too, as I am sure we all can recognize, that an outside agency coming in and pointing out a deficiency, can stimulate action that otherwise would not be taken, despite the efforts of the administrator or chief of staff to shake the group out of its lethargy and bring this about.

Let me, then, show you parts of a typical monthly report that we have received and that indicate the reasons for the down-grading of certain of the hospitals involved. Of course the names of the hospitals have been deleted as the information is

confidential. You can see what some of the commoner deficiencies are. (Figures 1,2,3,4.)

I am sure that in many instances the improvements required by the Commission were well known to the administrators but that they had been unable to bring them about by persuading the trustees to spend the money perhaps, or the staff to spend the time and effort, as the case might be, to accomplish them.

What then, let us ask, has the Joint Commission accomplished by its years of continuous effort and at great expense? You can answer this question as well as I, but I shall attempt to do so. As a gen-

*continued on next page*

eral statement I believe we can say that it has helped, and occasionally perhaps coerced, hospitals into improving the care of their patients where such improvement could be demonstrated to be needed. Also, by giving full accreditation to hospitals where the care could be shown to be fully up to standard and no serious deficiencies could be found, it has been a means of certifying to the public that full confidence in the work of such hospitals is justified. And its work and criticisms have not been confined to the small community institutions. In the case of a few well-known university hospitals definite deficiencies have been pointed out and the adoption of a "holier than

thou" attitude on their part has not prevented such hospitals from being down-graded. In some instances unpleasant publicity and severe criticism of the Commission has resulted, but, apparently this has been a matter of attempted face saving and in the case of more than one such hospital it has been privately admitted to the Commission that the criticism and the resulting action has been the best thing that could have happened to these hospitals. I have been told that a striking instance of this type of situation is to be included in a popular article on the Joint Commission which it is hoped will be published in a well-known magazine.

Surveyor: \_\_\_\_\_, M.D.

Member Organization: J.C.A.H.

	Beds	Previous Survey		Present Survey Recommendations		
		Date	Result	Date	Surveyor	Final
1	225	'57	3 yr.	5- 2-60	3 yr.	3 yr.
	2666	'57	3 yr.	5- 3-60	NA	NA
	147	'57	3 yr.	5- 6-60	3 yr.	3 yr.
4	244	'57	3 yr.	5- 9-60	1 yr.	1 yr.
	242	'57	3 yr.	5-10-60	3 yr.	3 yr.
	130	'57	3 yr.	5-11-60	1 yr.	1 yr.
2	100	'57	3 yr.	5-12-60	3 yr.	3 yr.
	136	'57	3 yr.	5-13-60	3 yr.	3 yr.
	107	'57	3 yr.	5-16-60	3 yr.	3 yr.
	91	'57	3 yr.	5-17-60	3 yr.	3 yr.
	140	'57	3 yr.	5-18-60	1 yr.	1 yr.
	288	'57	3 yr.	5-19-60	3 yr.	3 yr.
	143	'57	3 yr.	5-20-60	3 yr.	3 yr.

.....State Hospital — NA

Former A.P.A. approval.

Overcrowding.

Under staffed (both physicians and nurses).

Poor medical records.

Low autopsy rate.

.....General Hospital — 1 year

Clinical review not documented.

Poor medical records.

Committees of staff inactive.

.....Hospital — 1 year

Very weak medical record with many delinquencies.

Poor medical staff supervision.

.....General Hospital — 1 year

Staff bylaws incomplete.

Poor medical records.

Clinical review not documented.

FIGURE 3

The results of the monthly surveys by one surveyor. The reasons for the less than three-year approval for four hospitals are noted in lower half of figure.



It is of course impossible to persuade angels to accept employment as surveyors for the Commission. Those that we can appoint are human and are trying to do a hard job in a creditable manner. As far as my own experience with them goes, I have found them capable, courteous and very diligent experts, and when they have come to any of the hospitals in which I am interested I have hoped that they would point out all the deficiencies that could be found. There have, I know, been instances in which a surveyor has been found deficient, either personally or professionally, and has been dropped. In obtaining and training surveyors, checking their reports, dealing with a large volume of correspondence concerning surveys, traveling about and

speaking on the Commission's work, personally re-surveying a hospital in the rare instance of a really difficult situation, trying to carry out the policies of the commissioners and conducting their meetings and those of the Advisory Committee, and in many other matters, you can easily see that in the Chicago office a lot is going on. It is my own belief that the work of the Joint Commission as now constituted is carried on in all its phases by people of great integrity, high ideals, sympathetic understanding of hospital problems and rare good judgment. Its influence in promoting the health and welfare of American citizens is, in my opinion, very great.

.....	Hospital — 1 year
Poor staff organization.	
Poor medical records.	
Few autopsies.	
.....	General Hospital — 1 year
Clinical review not documented.	
No visiting pathologist.	
Low autopsy rate.	
Incomplete medical records.	
.....	Hospital — NA
Fire hazards.	
Little staff organization.	
No autopsies.	
Incomplete medical records.	

FIGURE 4

Reasons for down-grading of three other hospitals. Note listing of "fire hazards," a frequent cause of reduction of accreditation.

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**SESQUICENTENNIAL YEAR . . . MAY, 1961-MAY, 1962**

**THE RHODE ISLAND MEDICAL SOCIETY**

**REPORT ON ACTIONS OF THE HOUSE OF DELEGATES  
AMERICAN MEDICAL ASSOCIATION  
FOURTEENTH CLINICAL MEETING  
NOVEMBER 28 - DECEMBER 1  
WASHINGTON, D. C.**

CHARLES J. ASHWORTH, *Delegate*

**A**N INCREASE IN DUES for all members of the American Medical Association, as recommended by the Board of Trustees, was one of the important items approved by the House of Delegates at the Washington meeting last month. It is ten years since a raise in dues has been asked, yet a significant expansion in the scope of activities has taken place during this period. The Board's original suggestion stipulated an increase of not less than \$10.00 and not more than \$25.00 effective January 1, 1962. The reference committee's report adopted by the House set the figure at \$20.00, asking an increase of \$10.00 January 1, 1962 and an additional \$10.00 January 1, 1963.

These funds are to be used to inaugurate or expand a number of programs including:

1. Financial assistance to medical students.
2. Continuing education for practicing physicians.
3. Health advice to the lay public.
4. Medical research.
5. The expansion by the Communications Division of its program of faithfully portraying the image of the American Medical Association.

It is important, the House emphasized, that the Board of Trustees report recommending a dues increase be transmitted in essence to the grass roots level.

The reference committee on Insurance and Medical Service, upon which your delegate served considered particularly two important items, among many — Voluntary Health Insurance and Health Care for the Aged. The following substitute resolutions were finally adopted in place of three resolutions submitted, plus a Board of Trustees report:

"Whereas, It has been widely recognized that voluntary health insurance is the primary alternative to a compulsory governmental program; and

"Whereas, The public has shown its confidence in this voluntary system; and

"Whereas, Current social, political and economic developments compel a new and revital-

ized effort to make voluntary health insurance successful; and

"Whereas, the American Medical Association has consistently pledged itself to make available the highest type of medical care; therefore be it

*Resolved*, that the House of Delegates direct the Board of Trustees and the Council on Medical Service to assume immediately the leadership in consolidating the efforts of the American Medical Association with those of the National Association of Blue Shield Plans, the American Hospital Association and the Blue Cross Association into maximum development of the voluntary, non-profit prepayment concept to provide health care for the American people; and be it further

*Resolved*, that similar leadership be undertaken to co-ordinate the efforts of private insurance carriers through conferences with their national organizations; and be it further

*Resolved*, That, where feasible, efforts be made to co-operate with representatives of other types of medical care plans, other professional groups, and representatives of industry, labor and the public at large."

In dealing with health care for the aged, the House simply reaffirmed the A.M.A.'s support of the Kerr-Mills bill, and its opposition to any legislation involving the use of the OASDI mechanism for medical aid to the aged. The delegates also urged all state and local medical societies to co-operate with the appropriate state officials and provide leadership in implementing the provisions of the Kerr-Mills Bill.

In connection with health care for the aged, the House suggested further experimentation in home care programs, homemaker services and visiting nurse services. The delegates also recommended an increased emphasis at all levels of medical education on the new challenges being presented to physicians in the health care of older persons.

The House agreed with a Board of Trustees report regarding Polio Vaccine which said:

"In view of the fact that oral polio vaccine will not be generally available in sufficient quantity in

*concluded on page 50*

## "..extraordinarily effective diuretic..."

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## A.M.A. DELEGATE'S REPORT

*concluded from page 48*

1961 for any large scale immunizing effort, the Board of Trustees of the A.M.A. strongly recommends that the medical profession encourage the widest possible use of the Salk vaccine for the prevention of poliomyelitis. The Salk vaccine has been proved to be effective and since there are still many segments of the population not immunized against poliomyelitis every effort should be made to encourage the general public to take advantage of the Salk vaccine without delay."

The Board report was amended to suggest that a proper committee be established by the A.M.A. to study the problems involved in administration of the new oral polio vaccine and to establish guides for physicians to follow when they are approached by various groups and asked for their support in administering oral polio vaccine.

The House approved a scholarship and loan program proposed by the Special Study Committee of the Council on Medical Education and Hospitals, and also urged that there shall be local participation in the program at the state and county level. In commenting on the two-part program, the House approved the following statement by the reference committee:

"This proposed program will provide concrete evidence of the American Medical Association's sincere desire to attract increasing numbers of well qualified young people to enlarge the ranks of our profession. Your reference committee recognizes that the program is wisely designed to allow for its enlargement through the support of individual physicians and other groups. Your reference committee was impressed with the enthusiastic support of this proposal indicated during the course of the discussion. There was indicated a desire that in the final formulation of the administrative details of this program, provision be made for widespread participation by individual physicians as well as county and state medical societies. The program will clearly assist in securing highly talented indi-

## RHODE ISLAND MEDICAL JOURNAL

viduals whose ability and leadership in all areas of medicine will be fostered and at the same time will bring needed financial assistance on a broad basis to medical students under a system in keeping with this Association's belief in individual responsibility."

The problem of foreign medical graduates, was resolved by a report which included the following statement:

"In order that those foreign physicians who have not yet been certified by the Educational Council for Foreign Medical Graduates might be given further opportunity to enhance their medical education, hospitals would be encouraged to develop special educational programs. Such programs must be of educational worth to the foreign graduate and must divorce him from any responsibility for patient care. Foreign physicians may participate in these programs until June 30, 1961, with approval of the Department of State so that their exchange visa will not be withdrawn before that time. This will also allow the non-certified foreign physician the opportunity to take the April, 1961, Educational Council for Foreign Medical Graduates examination."

In considering a wide variety of resolutions, annual and supplementary reports, the House also:

Approved continuing study and periodic re-evaluation of the trend toward locating *physician's offices* in or adjacent to hospitals;

Directed the Committee on Medical Care for Industrial Workers to carry out its duties as previously instructed and to prepare guides for physician relationships with *medical care plans* in conformity with the clear policies already laid down by the House of Delegates;

Approved a set of guides relating to drug expenditures for *welfare recipients*;

Asked the Board of Trustees to study the question of blood replacement responsibility and also the matter of establishing health insurance fee schedules for *surgical assistants*;

Urged the Board to make every effort to reduce the number of physicians who are non-dues-paying members and approved a three-year study report on the relationships of *physicians not-in-private-practice* to organized medicine;

Requested the Board to present a completed *retirement and disability* insurance program for A.M.A. members at the June, 1961, meeting, and

Agreed that the *General Practitioner of the Year Award* should be continued as at present.

Named as 1960 General Practitioner of the Year was forty-four-year-old Doctor James T. Cook of Marianna, Florida, who was selected for his dedication to both medical practice and service to the community. Doctor Cook is the fourteenth recipient of the award.

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## NECROLOGY, 1960 — THE RHODE ISLAND MEDICAL SOCIETY

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*JOHN H. BROTHERS, M.D.*, died on November 4, 1960.

Doctor Brothers was born in Providence on February 16, 1895, and attended the old English High School. He was graduated from Valparaiso University in Indiana and he received his medical degree from Tufts School of Medicine in 1920. He interned at the Charles V. Chapin and Rhode Island hospitals.

He was a member of the staffs of St. Joseph's and Our Lady of Fatima hospitals. For many years he was physician at Providence College.

Doctor Brothers was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, and Providence Lodge of Elks.

*CHARLES E. BRYAN, M.D.*, of Riverside, died suddenly on March 8, 1960.

Doctor Bryan was born in North Plainfield, New Jersey, on December 25, 1915. After receiving his elementary and high school education in North Plainfield schools, Doctor Bryan was graduated from Springfield (Massachusetts) College in 1938, and from Hahnemann Medical School in 1942. He interned at Roger Williams General Hospital until he entered the army in 1943. As a medical officer he served at Army Air Force bases throughout this country.

Doctor Bryan was a member of the staff of Roger Williams General Hospital and he had been secretary of its medical staff for the past five years. He was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, and president of the General Practitioners of Rhode Island.

He also was a member of the Fraternal Order of Police Association in East Providence, the Riverside Businessmen's Association, Riverside Congregational Church, Rhode Island Badminton Association, and he was a past president and one of the founders of Kindbrin Swimming Club in Riverside.

*JOHN E. DONLEY, M.D.*, of Providence, died on September 17, 1960 after a short illness.

Doctor Donley was born in Providence on January 30, 1880, and he received his elementary education in the schools in Providence and he was graduated from Classical High School. He received

the degrees of Bachelor of Arts and Master of Arts from Seton Hall University in South Orange, New Jersey. He matriculated at the Medical School of the University of Pennsylvania and he was graduated a Doctor of Medicine in 1902. He did postgraduate work at the University of Pennsylvania and served an internship at St. Mary's Hospital in Philadelphia. He established himself as a practitioner of medicine in Rhode Island in 1904.

Doctor Donley was on the staffs of the following hospitals: St. Joseph's, Roger Williams, Miriam, Rhode Island, Charles V. Chapin, Butler, Pawtucket Memorial, Woonsocket, and Westerly.

He had been the recipient from the Seton Hall University and Providence College of the honorary degree of Doctor of Laws for his outstanding work in medicine.

In 1935, Theodore Francis Green, then governor, appointed him director of the state Department of Public Welfare and he served in that post four years. He headed the Rhode Island Curative Center from the time it was established in 1944. The center, the first of its kind in the United States, was designed to give injured workmen treatment to enable them to return to industry as quickly as possible.

He was an incorporator and a founder of Providence College.

In 1953 he was cited by President Eisenhower's National Employ the Physically Handicapped Committee for his "outstanding services to the disabled in Rhode Island."

He was presented with the thirteenth annual Doctor Charles V. Chapin Award of the City of Providence in 1954. It was the first time that the award had gone to a physician.

Providence College had cited him for his work with premedical students.

Doctor Donley was president of the Providence Medical Association in 1931-1932 and president of the Rhode Island Medical Society in 1936-1937. He also served as president of the Rhode Island Society of Psychiatry and Neurology. Active for many years in the Rhode Island Medical Society, he was editor-in-chief of the RHODE ISLAND MEDICAL JOURNAL at the time of his death.

He was a former chairman of the Catholic Charities Appeal, and was a communicant of Saint Sebastian's Church.

Among his friends, Doctor Donley was well known for his extensive library. He remained a frequent reader of Latin and Greek literature. He was a member and a founder of the Medical History Club of Providence and was a member of The Rhode Island Historical Society. He also belonged to the Beaumont Club of Yale University.

**FERNAND J. HEMOND, M.D.**, of West Warwick, died on March 1, 1960 after a short illness.

Doctor Hemond was born on April 13, 1903, in Woonsocket. After graduating from St. Ann's College, de la Pocatiere, P. Q., he entered Laval University Medical School from which he was graduated in June, 1931. He interned at St. Luke's Hospital in Pittsfield, Massachusetts.

Doctor Hemond had been in the general practice of medicine in the Pawtuxet Valley since July, 1932, and he was a former medical examiner.

Doctor Hemond was active in Franco-American circles throughout the state, including the Association des Médecines de Langue Française of Canada, the Association des Médecines Langue Française de la Nouvelle Angleterre, of which he was a former president, the Club Frontenac of West Warwick, which he founded and of which he was a past president, and the Club Marquette of Woonsocket.

Doctor Hemond was a member and past president of the Kent County Medical Society, and a member of the Rhode Island Medical Society.

He was a member of the Holy Name Society of St. John's Parish in West Warwick and the organizer of closed retreats for Catholic laymen in the Pawtuxet Valley.

**ARTHUR HOLLINGWORTH, M.D.**, of North Scituate, died at his home on June 26, 1960.

Doctor Hollingworth was born in Pawtucket, Rhode Island, in 1873 and he attended local schools there before graduating from Brown University. Doctor Hollingworth was also graduated from the University of Pennsylvania Medical School in 1898. He then interned at Rhode Island Hospital.

In 1901 he set up a general practice in Providence where he later specialized in surgery.

Doctor Hollingworth is often credited with the first successful cancer operation in Rhode Island and the first successful blood transfusion.

Entering semi-retirement in 1934, Doctor Hollingworth transferred his practice to North Scituate where he retired in 1940. He had been on the staff at Rhode Island Hospital from the time he started practice until he retired in 1940, and he had

been a consultant at the hospital until the time of his death.

Doctor Hollingworth was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, and he was a former member of the Providence Art Club.

**NATHAN J. KIVEN, M.D.**, of Providence, president of the Rhode Island Heart Association, and chief of the cardiopulmonary diagnostic clinic at the Miriam Hospital, died on October 16, 1960.

Doctor Kiven was born in Boston, Massachusetts, on July 18, 1910. He was graduated from the University of Colorado and later from the Denver College of Medicine. He interned at Queen's General Hospital on Long Island and was a resident physician at Sea View Hospital on Staten Island, New York.

Doctor Kiven entered the army on December 14, 1940 as a medical officer and he served at Fort Dix, New Jersey, and in the European theater. He attained the rank of major. He was commanding officer of the 26th Hospital Train.

After his discharge in 1946 he started his medical practice in Providence, specializing in internal medicine. He was on the staffs of the Rhode Island, the State, Chapin, and Miriam hospitals.

Elected president of the Rhode Island Heart Association in February, 1960, Doctor Kiven had previously served the organization as vice president, chairman of the program committee, and as a member of its research committee. He was an assembly delegate to the American Heart Association and he had been a member of the board of directors for three years.

He was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, the American Heart Association, Phi Epsilon Medical Fraternity and the Trudeau Society.

**ARSHAG DER MARGOSSIAN, M.D.**, a leader of the Armenian-American ethnic group in Rhode Island and long beloved of his people, died on January 9, 1960, after a short illness in the Rhode Island Hospital, at the age of eighty-seven.

Born in Harpoot, Turkey, on November 21, 1872, Doctor Margossian barely escaped the 1895 Turkish massacres in the region around Harpoot. After his graduation from Euphrates College, an American missionary school in Harpoot, he decided to study medicine in Beirut, Syria. A short time later Doctor Margossian escaped to the United States, arriving in Fall River and after several months there he came to Providence. In this country he did undergraduate work at Yale University and he was graduated from Jefferson Medical College in Philadelphia in 1901.

*continued on next page*

At this time Doctor Margossian started his practice of medicine in Providence. He was the first and, until 1916, the only Armenian doctor in Rhode Island. In those early days he had to be social worker, family peacemaker, interpreter and employment agent for his people, as well as the family doctor. In that pre-specialization era he practiced surgery, pediatrics, obstetrics, gynecology, orthopedics and virtually the whole range of the medical art. Doctor Margossian delivered more than five thousand babies during his years of practice.

For many years Doctor Margossian was active in the Armenian Democratic Liberal party and was a former president of that organization. He was also a past president of the Armenian Educational Society of Harbuseh. His medical affiliations included membership in the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association. He was also a member of the Armenian Congregational Church.

*ROBERT E. MARTIN, M.D.*, of Providence, died suddenly on March 23, 1960.

Doctor Martin was born in Providence on August 13, 1922. He was graduated from Moses Brown School and Brown University, class of 1944, and received his Doctor of Medicine degree from Cornell Medical College in 1946. He served his internship at Rhode Island Hospital from 1946 to 1947. He then entered the United States Navy and he was stationed at the Naval Hospital in Newport from 1947 to 1949.

Doctor Martin was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association. He was a diplomate of the American Board of Obstetricians and Gynecologists. He also was a member of the New England Obstetrical and Gynecological Society and he was project obstetrician for the government's Child Development Study in Washington, D. C. He was also a consultant to the collaborative study on obstetrical protocol of the National Institute of Health.

A sports car enthusiast, Doctor Martin was a member of the Narragansett Sports Car Club and the Sports Car Club of America.

Doctor Martin was on the staffs of the Rhode Island Hospital and the Providence Lying-In Hospital.

*FRANK J. McCABE, M.D.*, an eye, ear, nose and throat surgeon in Providence for forty years, died on September 6, 1960.

Doctor McCabe was born in Pepperell, Massachusetts, on May 3, 1880. He graduated from Dartmouth College in 1905 and he received his medical degree from the Harvard Medical School in 1908.

After internships at Newton Hospital and Carney Hospital in Boston, he opened a general practice in North Easton, Massachusetts. In 1915 he interned at the Massachusetts Eye and Ear Infirmary.

As a young man he was active in sports, playing baseball and football at Dartmouth and professional baseball in the old Eastern League, the New York State League and the New England League while attending medical school.

Doctor McCabe was a visiting surgeon on the staffs of Rhode Island, Saint Joseph's, the Charles V. Chapin, Pawtucket Memorial, Roger Williams General, Westerly, and Our Lady of Fatima hospitals.

He was a member of the American College of Surgeons, the American Medical Association, the New England Ophthalmological Society, the New England Otological Society, the Rhode Island Medical Society, and the Providence Medical Association.

For many years he was active in the Knights of Columbus as a member of Tyler Council and Bishop Hendricken Assembly, Fourth Degree, and he was state deputy in 1925 and 1926.

*CHARLES A. McDONALD, M.D.*, of Providence, died on July 5, 1960 after a long illness.

Doctor McDonald was born in Providence and lived in that city during his entire lifetime.

Upon graduating from Brown University in 1903 he entered Harvard Medical School where he received his medical degree in 1907, and he then began his practice of medicine.

Doctor McDonald served as a specialist in neurology and psychiatry at Harvard Medical School from 1922 until 1927, when he became a member of the faculty at Brown in the biology department. Later he was named director of the university's health service and professor of health and hygiene.

Doctor McDonald served as chief of the neurology and psychiatry departments at both Rhode Island and Saint Joseph's hospitals, and from 1935 to 1937 was chief of the state Hospitals and Infirmary Division.

In 1941 he was named by Governor J. Howard McGrath to a seven-member committee to draw up a long-term program for the development of the state institutions.

In June, 1953, he received the honorary degree of Doctor of Science from Brown University.

He was a member of the Providence Medical Association, Rhode Island Medical Society, American Medical Association, American Neurological Association, American Psychiatric Association, Association for Research in Nervous and Mental Diseases, American Psychopathological Association, and New England Society of Psychiatry.

*JOSEPH B. McKENNA, M.D.*, a practicing physician in Woonsocket for twenty-two years, died on December 20, 1960.

Doctor McKenna was born in Dorchester, Massachusetts, on February 10, 1911. He was graduated from Boston College in 1932, and from Tufts Medical School on June 6, 1936.

Doctor McKenna practiced medicine in Uxbridge, Massachusetts, from 1938 to 1940. He was Woonsocket police physician since 1958, and was a past president of the Woonsocket District Medical Society, and a director of Mercy Hospital in Woonsocket.

Besides his affiliation with the Woonsocket Medical Society, Doctor McKenna was also a member of the Rhode Island Medical Society and the American Medical Association.

*JOHN A. MELLONE, M.D.*, a practicing physician in West Barrington for the past fourteen years, died suddenly on May 31, 1960.

Doctor Mellone was born in Providence on February 2, 1908. He was a graduate of Classical High School, Providence College, class of 1929, and Georgetown University Medical School, class of 1933. He served his internships at Saint Joseph's Hospital from 1933 to 1934, and at Charles V. Chapin Hospital from 1934 to 1935.

Doctor Mellone opened his practice of medicine in Bristol in 1935, where he practiced until 1941.

From 1941 to 1945 he was in the army and he served in England and France, retiring as a lieutenant-colonel to again begin private practice, this time in West Barrington.

Doctor Mellone was the senior physician at the Rhode Island Veteran's Home in Bristol, a member of the Bristol County Medical Society, the Rhode Island Medical Society, the American Medical Association, the Holy Name Society of St. Luke's Church in West Barrington, Bishop Hickey Council, Knights of Columbus, of Riverside and Barrington, Disabled Officers Association of Washington, D. C., Barrington Post, American Legion, West Barrington Post, VFW, and DAW Post of Bristol. He was also the Barrington police surgeon.

*MIHRAN MISSIRLIAN, M.D.*, of Providence, died on November 8, 1960.

Doctor Missirlian, who was born in Harpoot, Armenia, August 15, 1892, obtained his premedical at the Euphrates College of the American Missionary School. He received his medical degree at the Sorbonne in Paris in 1923. He interned in Paris at the Cochen Hospital and Ste. Antoine Hospital.

A linguist, he spoke Russian, French and Armenian as well as English. Before coming to the United States he was a medical officer with the Second Black Sea Labor Battalion of the British

Army stationed in the Mediterranean area.

He was a major in the medical corps of the Air National Guard, and a member of the Civil Aeronautics Administration, the Aero Medical Association, and the Civil Aviation Medical Association of Paris. For many years he served as examining physician for the Federal Aviation Agency in Rhode Island.

Doctor Missirlian was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, and a staff member of Rhode Island Hospital.

*LOUIS A. NORMANDIN, M.D.*, of East Providence, died while vacationing in Florida on February 24, 1960.

Doctor Normandin was born in Fall River, Massachusetts, on March 1, 1893. He studied at the Christian Brothers School in Fall River, and at Williston Academy at Easthampton, Massachusetts. Enrollment in the premedical course at Tufts College preceded his study in Tufts Medical School, from which he was graduated in 1919.

Internship at Saint Elizabeth's Hospital in Boston and the Cambridge Tuberculosis Hospital preceded a year's private practice in Cambridge. In May, 1922, at his own request, he was transferred to the sub-district regional office of the Veterans' Administration in New Bedford, where he served as chief medical officer and later as manager. Consolidation of the southeastern Massachusetts territory and the Providence office resulted in his transfer to the bureau in this city in 1925. In 1928, he was promoted to chief medical officer of the local bureau and manager in 1934.

While serving in the New Bedford office Doctor Normandin joined the Massachusetts National Guard, being assigned as first lieutenant with the 241st Coast Artillery. Three years later he was promoted to a captaincy. When Doctor Normandin finally established residence in this Rhode Island he transferred to the National Guard here and was assigned as commanding officer of the Hospital Company at the Cranston Street Armory. Subsequently, he was made a major.

Doctor Normandin was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association.

*EMERY P. PELLETIER, M.D.*, of Providence, died on August 8, 1960, after a brief illness.

Doctor Pelletier was born in Manville, Rhode Island, on April 30, 1892. He was graduated from Classical High School, attended Brown University, and graduated from McGill University in Quebec, and he received his medical degree from the University of Montreal in 1927. Doctor Pelletier served his internship at Woonsocket Hospital.

*continued on next page*



Doctor Pelletier was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, and the Providence Lodge No. 14 B.P.O. Elks.

Doctor Pelletier was on the staff at Saint Joseph's, Roger Williams, and Notre Dame hospitals.

*HERMAN C. PITTS, M.D.*, of Providence, one of Rhode Island's most prominent physicians, died on August 5, 1960.

The son of an Episcopal minister, Doctor Pitts was born in Saginaw, Michigan, in 1875. Because of his early interest in medicine Doctor Pitts was accepted as a student at Yale Medical School without previous college training. He was graduated from Yale in 1900, receiving a medal offered annually to the man graduating first in his class. After an internship at Rhode Island Hospital, he was a resident for a time at New York Lying-In Hospital. In 1903 Doctor Pitts established himself in the general practice of medicine in Providence after completing additional studies at Johns Hopkins Medical School in Baltimore, but he soon began to specialize in surgery.

Doctor Pitts will long be remembered in the United States for pioneer work in the treatment of cancer and for painstaking clinical research in quest of a cure. In 1922 he started a clinic at Rhode Island Hospital, where he later was to be chief of the surgical staff, for the detection and treatment of cancer in women. At about the same time he began speaking before nonmedical groups so that information on the cancer problem and the means of alleviating it would be disseminated more widely than it had been up to that time.

For many years he took an active interest in the cancer programs at Rhode Island institutions, such as the hospitals, Brown University, and Providence College. Doctor Pitts had suggested that Brown, Providence College, Rhode Island Hospital and the Chaffee Home might correlate their efforts and share their findings.

Doctor Pitts had carried on extensive research himself which was based on the files of 15,000 cancer cases in Rhode Island. His objective was to see whether the various treatments and the results obtained from them would suggest any course of investigation that would lead to the conquering of cancer.

In co-operation with the late Doctor Albert D. Meade and Doctor J. Walter Wilson of the Brown biology department, Doctor Pitts had aided in launching the university's cancer-research program.

In 1942 the Men's Club of Temple Emanu-El named him to receive its community service award for "outstanding achievement in the field of civic

improvement, human betterment and advancement of American ideals."

As president of the American Cancer Society Doctor Pitts helped to organize the early campaigns to enlighten the public about cancer and its symptoms, and in 1953 received a medal from that organization in reward for his outstanding services.

At home, meanwhile, he was also aware of the need for a home for terminal care of cancer patients and he became the president of the Hattie Ide Chaffee home upon its establishment.

The Rhode Island General Assembly passed a resolution in 1957 expressing the appreciation of the state for "his outstanding contribution to cancer control activities."

In 1958 Brown University recognized his contributions to the University and to the community by bestowing on him an honorary degree of Doctor of Science.

Besides being a member of the American Cancer Society, Doctor Pitts was also a member of the Providence Medical Association, the Rhode Island Medical Society, of which he was a former president, the American Medical Association, the American College of Surgeons, and the New England Surgical Society. He served as a member of the board of managers of the Saint Elizabeth Home and a member of the board of governors of the English-Speaking Union. He was also a devoted trout fisherman, a facet of his character that was noted by the University Club when it bestowed on him its man-of-the-year award.

*HAROLD W. TAYLOR, M.D.*, of Little Compton, a practicing physician in Rhode Island since 1948, died on September 7, 1959 at the age of seventy-two.

Born in Beverly, New Jersey, on October 13, 1886, Doctor Taylor received his premedical education at Columbia University and he received the degree of Doctor of Medicine from Columbia University College of Physicians and Surgeons in 1915. He served his internship at New York Hospital from 1915 to 1916 and at Presbyterian Hospital (New York) from 1916 to 1917.

Doctor Taylor practiced medicine for many years in New Jersey, moving to Little Compton in 1948.

He was a member of the courtesy staff of Saint Luke's Hospital in New Bedford.

(*Editor's Note:* Doctor Taylor's obituary was omitted inadvertently in the 1959 Necrology published in this Journal, and it is therefore now included in the 1960 listing.)

*MARGARET B. ROSS, M.D.*, of Rumford, died suddenly on June 26, 1960.

Doctor Ross was born in Holyoke, Massachusetts, on October 12, 1899, and she received her



early education in local schools there. She received her Bachelor of Science degree at Tufts College in 1919 and she was graduated *cum laude* from Tufts Medical School in 1922. She then interned at Western Pennsylvania Hospital from 1922 to 1923.

From 1926 to 1929 Doctor Ross was city physician of Holyoke, Massachusetts, and during the same period was chief obstetrician for the Providence Hospital in Holyoke and assistant surgeon at Holyoke Hospital.

Doctor Ross was the first woman in Rhode Island to join the armed forces in the Second World War.

Doctor Ross was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association.

**FLORIAN G. RUEST, M.D.**, of Cranston, medical director of the State Division of Tuberculosis Control and president of the New England Tuberculosis Conference, died on June 3, 1960.

Doctor Ruest was born in Pawtucket, Rhode Island, in 1898 and he was graduated from La Salle Academy in 1916. He was a graduate (*cum laude*) of Holy Cross College in 1920, and of Harvard Medical School in 1924. He interned at Rhode Island Hospital and Providence Lying-In Hospital, and he then went into general practice in Providence in 1926.

Doctor Ruest was active in the treatment and control of tuberculosis in Rhode Island for many years. He joined the staff of the Doctor U. E. Zambarano Memorial Hospital at Wallum Lake in 1942, and stayed there until he became medical director of the Division of Tuberculosis Control in the State Department of Health in 1950. He was a member of the board of directors of the Rhode Island Tuberculosis and Health Association, a member of the American Trudeau Society, the medical division of National Tuberculosis Association, the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, and he was a former member of the New England Obstetrical and Gynecological Society.

Doctor Ruest was also interested in music and he was a member of the choral group choir of Saint Charles Borromeo Church. He was a past president of the Holy Name Society of Saint Charles Borromeo parish.

**JAMES J. SHERIDAN, M.D.**, former Cumberland health officer and school physician, died at his home on October 15, 1960.

Doctor Sheridan was born in Blackstone, Massachusetts, on March 6, 1902. He attended elementary schools in Blackstone and he was a graduate

of Blackstone High School. He received his degree of Bachelor of Science in Medicine at Georgetown College in 1929 and his degree in medicine from Georgetown University School of Medicine in 1931.

After serving his internship at St. Elizabeth's Hospital, Brighton, Massachusetts, from July 1, 1931 to April 30, 1933, Doctor Sheridan began the practice of medicine in Valley Falls on August 8, 1933. He continued his practice there until 1952, when he opened an office in Pawtucket.

He served as Cumberland school physician from 1947 to 1954 and as town health officer for four years until 1956. Since 1954 he was a medical rating specialist at the Veterans Administration Hospital, Davis Park, Providence.

Doctor Sheridan was a physician for the Selective Service system during World War II. He was on the medical staff at Memorial Hospital, Pawtucket, from 1934 to 1950 and later he was a member of the medical associate staff there.

He was a member of the Pawtucket Medical Association, the Rhode Island Medical Society, the American Medical Association, Alpha Kappa Kappa medical fraternity, Georgetown University Alumni Association, Georgetown University Club of Rhode Island, the American Red Cross, Pawtucket Lodge of Elks, St. Thomas Council, Knights of Columbus, and the Holy Name Society of Saint Patrick's Church, Cumberland.

**RICHARD K. WHIPPLE, M.D.**, of Rumford, died on June 16, 1960, after a long illness.

Doctor Whipple was born in Ithaca, New York, on December 5, 1916, and he attended elementary schools in Springfield, Vermont. He received his A.B. degree from Brown University in 1938 and his Doctor of Medicine degree from Yale University in 1942. He served his internship at Rhode Island Hospital.

From January, 1944 to April, 1945 Doctor Whipple served in the army as a first lieutenant.

Doctor Whipple was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association.

#### FROM THE EDITOR'S DESK . . .

Appearing in this issue is an excellent review on chest trauma titled *Management of Thoracic Trauma*. This paper has been selected as the first of a projected series of reviews on various medical subjects to be published under the heading of *Progress Notes*. These reviews will be characterized by readability rather than exhaustive bibliography.

SEEBERT J. GOLDOWSKY, M.D.  
Editor-in-Chief



### **Medical Officer Sought for VA Rating Board**

The Providence Regional Office of the Veterans Administration is seeking a physician to serve as medical officer on its Rating Boards. The starting salary is \$9,735 annually. The rating boards are three member teams of rating specialists (medical, legal and occupational) who rate claims of veterans for disability compensation or pension. The work is sedentary with regular working hours, vacation and sick leave benefits, coverage under Civil Service Retirement or social security system, low cost life insurance, and health insurance. Applicants must be citizens or owe allegiance to the United States, graduates of recognized medical schools, have record of approved internship, and have had at least one year of progressively responsible professional experience in the field of medicine.

Any doctor interested should communicate with Mr. John L. Reavey, Manager of the Providence office at 100 Fountain street.

### **Federal Government Study Shows Majority Have Voluntary Health Insurance**

About two thirds of the civilian noninstitutional population of the United States had some form of voluntary health insurance during the last half of 1959, according to a new report just published by the Public Health Service's U. S. National Health Survey.

In general the rates of coverage were highest in the age groups in which the working population is concentrated, in urban and non-farm areas, in the middle and upper income brackets, and in the Northeast and North Central regions of the country.

The report is based on household interviews conducted during the period July-December 1959, in a representative sample of approximately 19,000 households containing 62,000 persons.

The figures show that about 67 per cent of the civilian noninstitutional population had some hospital insurance, 62 per cent was reported to have surgical insurance, and 19 per cent to have insur-

ance against the cost of physician visits at home or in the doctor's office. They do not indicate whether the insurance paid the entire bills or only parts of them.

Among people under the age of 25, 66 per cent had hospital insurance, 61 per cent had surgical insurance, and 19 per cent had doctor-visit insurance. In the age group 25-44, 74 per cent had hospital insurance, 69 per cent had surgical insurance, and 23 per cent had doctor-visit insurance. In the age group 45-64, the proportions were 71 per cent, 65 per cent, and 20 per cent; and among persons age 65 and over they were 46 per cent, 37 per cent, and 10 per cent.

Health insurance coverage was generally highest in the Northeast and North Central regions of the United States and lowest in the South. The proportion covered in the West was somewhat lower than the national average for both hospital and surgical insurance, but for doctor visits it was considerably higher than in the other regions.

### **More Dental School Applicants Reported in 1960**

A "substantial upturn" in the number of applicants for dental schools examined last fall was disclosed recently by the American Dental Association.

There was a 17 per cent increase in the number of dental school applicants tested last fall compared with a year ago.

The 1,561 applicants examined compare with 1,332 in 1959 and 1,486 in 1958.

The increase was hailed as a "step in the right direction" by Doctor Shailer Peterson, secretary of the Association's council on dental education.

But Doctor Peterson tempered his optimism with a warning that the dental profession still faces a stiff challenge in the area of recruitment if the shortage of dentists predicted for 1975 is to be headed off.

The Association council conducts an aptitude testing program for applicants to all 47 United States dental schools which enable schools to pre-

*continued on page 60*



## IN COLDS AND SINUSITIS— THE RIGHT AMOUNT OF "INNER SPACE" RIGHT AWAY

Neo-Synephrine hydrochloride relieves the boggy feeling of colds immediately and safely, without causing systemic toxicity or chemical harm to nasal membranes. Turbinates shrink, sinus ostia open, ventilation and drainage resume, and mouth-breathing is no longer necessary.

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**NASAL SOLUTIONS AND SPRAYS**

## THROUGH THE MICROSCOPE

continued from page 58

dict with a high degree of accuracy the probable success of students.

**Federal Employees Health Plan Due for Changes**

Joseph Young, staff writer for the *Washington (D.C.) Star*, writing in that newspaper on November 27, reported that the Civil Service Commission already is receiving proposal from government employees for changes in the Federal employee health insurance program when new contracts are written this coming spring. According to writer Young the Commission will negotiate new contracts with the various health and insurance carriers, preparatory to the "open" period next October when employees again will enroll under a health insurance plan of their choice.

Among the proposals and complaints being made to the CSC, according to Young, are these:

1. Parents and other family members who are dependent on the employee for total financial support should be covered by the health insurance program.

At present only the employee's spouse and minor children are covered by the program.

Employees complain that it is unfair to exclude a parent or a close relative whose support is entirely dependent upon them. These persons are

## RHODE ISLAND MEDICAL JOURNAL

members of the family household in the strictest sense of the word and should be covered, they contend.

2. Employees who previously were under Blue Cross-Blue Shield before the government's program went into effect, complain that their present Blue Cross-Blue Shield coverage in some aspects is less than it was before.

They can't understand this, observing the total premium paid to Blue Cross-Blue Shield — their contribution plus the government's — is far more than the premium they paid previously. Yet in some aspects the benefits are less, they complain.

CSC officials acknowledge the problem exists, declaring that on the over-all government-wide program some benefits offered were not as high as were previously given to enrollees. On the other hand, they declare that employees now have "catastrophic" type benefits they didn't have before.

The employees contend that practically all of their natural expenses are of the non-catastrophic type and that they find themselves worse off in some respects than were before. This is one of the problems the CSC must face in renegotiating the new contracts.

3. Women employees with non-dependent husbands object strongly to paying higher premiums than other employees. They want to be treated on the same basis as the rest of the government's workers.

**Women Prime Victims of Diabetes**

Women suffer from diabetes more frequently than men, the Health Insurance Institute reported recently.

There are 871,000 female and 660,000 male diabetics in the United States for a total of 1.5 million persons so afflicted, the Institute said in its report based on data from the U. S. National Health Survey.

Although diabetes mellitus does not rank high in the number of cases, it is eight among the ten leading causes of death, being responsible for 27,500 deaths in the year ending December 1958, said the HII.

The diabetes rate works out to an average of nine cases per 1,000 population, divided between ten cases per 1,000 females and eight cases per 1,000 men.

By age, the highest rate is in the 65-74 age bracket where 50 of every 1,000 women and 34 of every 1,000 men are diabetics, said the Institute. However, from age 75 onward, the rate decreases to 39 cases per 1,000 women and 32 cases per 1,000 men.

Ninety-two per cent of the diabetics were under medical care, and 90 per cent said they had no chronic limitation of mobility due to the disease.

## TESTIMANIMAL



Mane-ly I drink

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Seventy-five per cent of the sufferers from diabetes said the illness did not affect their day-to-day activities. The disease was responsible for some 1.7 million work-loss days among the "usually working" population, said the HII.

### **Sectional Meeting for Surgeons Listed for Philadelphia**

Surgeons, graduate nurses, and related medical personnel from all parts of the country are invited to attend the annual four-day Sectional Meeting of the American College of Surgeons in Philadelphia, March 6 through 9, 1961. Headquarters will be the Bellevue Stratford, Ben Franklin, and Sylvania hotels, with some sessions scheduled at leading hospitals in the city.

In length and scope this scientific meeting approaches that of the annual Clinical Congress of the College. The program will include hospital clinics, panel discussions, symposia, scientific papers, industrial exhibits, and medical motion pictures in general surgery sessions and in the specialties of obstetrics and gynecology, ophthalmology, otolaryngology, urology, orthopedic surgery, plastic surgery, pediatric surgery, and thoracic surgery.

"How I Do It" clinics, educational demonstrations by surgeons noted for specific techniques, will

be presented each morning during the meeting.

Doctor Jonathan E. Rhoads, professor of surgery, University of Pennsylvania Medical School, is chairman of the Local Advisory Committee on Arrangements.

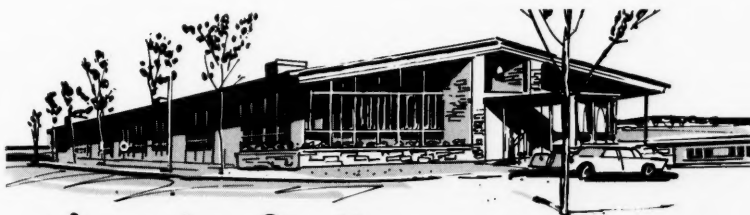
### **Most Workers Paid If Disabled off Job**

More than 43 million American workers are assured that their income will continue in the event they are disabled by off-the-job illness or injury, the Health Insurance Institute reported last month.

As of the end of 1959, insurance companies protected 32,869,000 persons against the loss of income due to disability, and 10,300,000 workers were protected by other arrangements such as formal paid sick leave plans of Federal, state and local governments; private industry; union plans, and employee mutual benefit associations.

The total of 43,169,000 persons so protected — representing 62 per cent of the civilian labor force of 69 million persons — did not include the millions of other employees with some degree of income protection through informal wage-continuation practices, said the Institute. In addition, workmen's compensation provides wage replacement and medical care benefits for workers who are disabled while on the job.

*concluded on next page*



## **Hattie Ide Chaffee**

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In insurance company loss-of-income protection, the insured person may receive, depending on the policy, up to 75 or 80 per cent of his take-home pay.

In the case of accidents, benefits usually start on the first day, and for sickness the common waiting period for benefits is eight or 15 days. However, the insured person may have these payments start one, two or three months after disability begins to coincide the waiting period with the termination of any disability payments made by the employer.

The 43 million persons covered at the end of 1959 was an increase of three per cent over 1958 and a jump of more than 12 per cent over the 38 million so protected at the end of 1952, said the Institute.

In 1959, insurance companies paid out \$912 million to replace income lost through disability, including payments made under the accidental death and dismemberment provisions of accident and health policies. This was an increase of seven per cent over the \$851 million paid out by insurance companies in 1958 and a jump of 79 per cent over the \$510 million paid out in 1952. And in the first nine months of 1960, more than \$691 million in loss-of-income benefits were paid by insurance companies.

It seems to me that modern science has created a state of affairs which has no exact precedent in history. As a result of medical progress, the human population is rapidly increasing in numbers and changing in biological characteristics. On the other hand, technology is creating a new environment to which man must become adapted in order to survive. It is not for physicians, of course, to decide what modern life should be, because this choice involves value judgments which transcend medical evaluation. But the final decision should be conditioned by a kind of biological wisdom that only medicine can provide. Thus, whether he wants it or not, the physician will be compelled by the very power of the means at his command to accept increasingly larger social responsibilities. He will have to develop a philosophy taking into consideration not only the welfare of the individual patient, but the interests of the community and indeed the future of the human race. When theoretical physics became an instrument of political power after Hiroshima, physicists were forced to assume responsibility in power politics. Likewise, the power of physicians over life and death has become so great that medicine can no longer be considered apart from social philosophy.

Excerpt from *THE PHILOSOPHY OF MEDICINE* in 1985 by RENÉ J. DUBOS, of the Rockefeller Institute for Medical Research, appearing in the Twenty-fifth Anniversary Issue of *What's New*, published by Abbott Laboratories, November 1960.

### 150th Annual Meeting

May 2 and 3, 1961

### Common Cold Takes Heavy Toll

How common is the common cold? This common: In a year's time, there were 115 million colds in the United States severe enough to involve a restriction of activity or to require medical attention.

The Health Insurance Institute, in reporting recently this data extracted from the U. S. National Health Survey, pointed out that the total of colds excluded minor cases of sniffles-and-sneezes.

The 115 million relatively severe colds, said the Institute, made up a large portion of the 368 million acute conditions which were reported among the nation's civilian population during the one-year period ending in June 1959. The survey defined acute conditions as those which lasted less than three months and which restricted activity or needed medical care.

In addition to the colds, there were some 27 million cases of infections such as tonsillitis, sinusitis and laryngitis which made for a grand total of 142 million upper respiratory conditions in a year.

Other prosaic ailments included 20 million cases of the "virus," five million cases of indigestion and similar symptoms, and nearly three million headaches acute enough to restrict activity or require a doctor's care, stated the Institute.

*Children Affected:* Almost half of the upper respiratory conditions occurred to children under the age of 15, averaging out to 1.3 such infections per child with girls being somewhat more susceptible than boys.

Breaking down the acute conditions by sex, women generally had a higher incidence rate in infections and illnesses while men led in accidents and injuries. The over-all incidence of acute conditions was 224 per 100 women to nearly 205 per 100 men.

Age plays an important role in the incidence of acute conditions, the institute said. The number of such conditions decreased for each succeeding age group from a high of 3.5 conditions per child under age five to a low of 1.3 conditions per person over 65.

These acute conditions caused the loss of 193 million days from work and 191 million days from school. Respiratory conditions, both upper and lower, were the major cause of the lost time, being responsible for 41 per cent of the days lost from work and 58 per cent of the school loss.

Of the 368 million acute conditions, 229 million required medical attention, and 46 per cent of these involved children under 15. Only 19 per cent of adults 45 or older with acute conditions consulted a doctor.

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**BOOK REVIEWS**

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*SYNOPSIS OF PATHOLOGY* by William A. D. Anderson. The C. V. Mosby Co., St. Louis, 1960. 5th Ed. \$9.25

The fifth edition of this book is a necessary expansion of the fourth. In the fifth edition, which has been increased by the addition of eighty-six illustrations and forty-six pages, one finds an admirable condensation of the entire field of pathologic anatomy, so that this book is almost a necessity for residents in pathology and the various clinical specialties, as well as for the practicing pathologist himself.

The first three chapters consider the fundamental pathologic processes. The following chapters take up the effects of various micro-organisms, as well as the effects of chemical poisons, nutritional deficiencies and disturbances of growth. The remainder of the book considers various diseases according to organs and systems.

Despite its small size, this edition, like its predecessors, is very abundantly and very well illustrated.

The only fault that I can find is that the print in this edition is not quite so sharp and clear as in the previous editions.

I recommend this book very highly.

L. W. FALKINBURG, M.D.

*CIBA FOUNDATION COLLOQUIA ON ENDOCRINOLOGY*. Vol. 13. Human Pituitary Hormones. Editors for the Ciba Foundation: G. E. W. Wolsteinholme and Cecilia M. O'Connor. Little, Brown & Co., Boston, (1960). \$9.50

This symposium was arranged in honor of Professor B. A. Houssay of Argentina and took place in Buenos Aires.

There were thirty-two international authorities participating in this symposium, including nine American scientists. It embraces the various scientific aspects of research on the human pituitary gland and is a good reference book for the interested internist who wishes to delve deeper into the subject from a purely laboratory point of view.

It is highly technical, very specialized, but still a good book for reference.

José M. RAMOS, M.D.

*MEDIEVAL AND RENAISSANCE MEDICINE* by Benjamin Lee Gordon. Philosophical Library, N. Y., 1959. \$10.00

This is the story of the Dark Ages in medicine, running to over 750 pages exclusive of notes and bibliography. Such a volume can and does cover a great many personalities, both well known and obscure, but unfortunately the sterility of the times is somewhat numbing. One tires of reading of the numerous useless compounds employed. Further, the book is marred by a lack of organization and often repetition. The sections devoted to the various plagues and epidemics are interesting and revealing, and the lengthy index makes a volume that is a useful reference for specific facts of the times. It is not, however, a book that will hold the interests of the average reader from cover to cover.

THOMAS PERRY, JR., M.D.

*WOMEN AND FATIGUE*. A Woman Doctor's Answer by Dr. Marion Hilliard. Doubleday & Co., Inc., Garden City, N. Y., 1960. \$2.95

This is a book about women's most frequent complaint, "fatigue," written by a woman doctor for women, but which men could read and thereby gain much help in understanding their women!

Doctor Hilliard describes the causes of fatigue from the standpoint of metabolism, stress, psychological reactions and personal relationships. She discusses the importance of faith in oneself and God during three significant phases of a woman's life — adolescence, marriage or career and the menopause.

She warns women about the false values of stimulants (medical or alcoholic) or affairs used to overcome fatigue, stating that if each woman tries to learn to know herself and to "love God and do as He pleases," she will be sure to do the right thing and thus will overcome her special fatigue problems.

KATHLEEN M. BARR, M.D.

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**LIBRARY HOURS — DAILY**  
**(Except Saturday and Sunday)**  
**8:30 A.M. — 4:30 P.M.**

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